COMMONWEALTH of VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

October 21, 2005

ADDENDUM No. 2 TO VENDORS:

Reference Request for Proposal:	**RFP 2006-02**
Dated:	**September 26, 2005**
Due:	**November 7, 2005**

RFP 2006-02 for a Prior Authorization Services Administrator: Attached are questions and responses related to this RFP.

Note: A signed acknowledgment of this addendum must be received by this office either prior to the due date and hour required or attached to your proposal response. Signature on this addendum does not substitute for your signature on the original proposal document. The original proposal document must be signed.

Sincerely,

Christopher M. Banaszak

Christopher M. Banaszak
Contract Officer

Name of Firm: _____

Signature and Title: _____

Date: _____

Question Number	Section/ Question	Comment	Response
1.	Cover Page	Do you have a time frame within which you think the answers to the questions will be provided?	Responses will be provided no later than October 21st.
2.	Section 1 Purpose & Definition Page 9	How will DMAS calculate the "proportionately higher score" that will be awarded to a QIO or QIO-like organization compared to calculating a score for a non QIO or QIO like organization?	CMS provides for a 75% FFP for programs for the performance of medical and utilization review by a utilization and quality control peer review organization or by an entity which meets the requirements of section 1152 of the Social Security Act. This will be evaluated by the evaluation team.
3.	Section 1 Purpose & Definition Page 9	CMS has implemented certain restrictions on QIOs regarding non-licensed personnel handling clinical information within Medicaid review processes. Will the Commonwealth please elaborate on the potential of a vendor having non-licensed personnel handle initial clinical reviews?	The RFP requires a sufficient number of professional and clinical staff, with the necessary knowledge, education, and experience (and license if applicable), to implement and operate the prior authorization system, and the concurrent review and utilization review processes. The Contractor is responsible for assuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations. This would include assurances of the Contractor to meet any QIO requirements, as applicable.
4.	Section 1 Purpose & Definition Page 9	May an entity which has been certified as a PRO-like entity by CMS serve as the prior authorization administrator for DMAS if it has a common parent corporation with a facility that is a DMAS provider of behavioral health services in Virginia? The PRO-like entity would implement procedures to avoid influence by its sister provider corporation on its prior authorization decisions.	Yes, Contractors can put together a proposal using other parties in either as a partnership or as a subcontractor. However, DMAS cannot comment on the validity of any potential proposal. The evaluation team does that. The bidders need to respond to the RFP and elaborate on the mechanisms and relationships they will use to meet the requirements. Each bid is evaluated objectively.
5.	Section 1 Purpose & Definition Page 10	The RFP states that the contractor will be responsible for the prior authorization of "carved out services" provided to MCO enrollees. How many MCO enrollees are eligible and/or receive carved out services? Is this number included in the number of FFS beneficiaries (344,000) quoted by the Department or will this estimate need to be adjusted by those Medicaid beneficiaries currently enrolled with a MCO and needing "carved out services"?	Services "carved out" of the MCO contract include: Community rehabilitation mental health services, mental retardation services, and substance abuse treatment services; School health services; Targeted case management services; Investigations by local health departments to determine the source of lead contamination; Abortions; Dental Services. Any prior authorizations required for these services shall not be performed under this contract.
6.	Section 1 Purpose & Definition Page 10	With the expansion of the State's MCO program in the next twelve months, will there be mandatory enrollment into MCOs, or will it be voluntary enrollment?	Enrollment will be mandatory.
7.	Section 1 Purpose & Definition Page 10	Are the numbers of recipients affected by program expansion mandated to join a MCO, or is it elective? If elective, historically, what percentage of recipients join MCOs within the first three years?	They are mandated to join the MCO.
8.	Section 1 Purpose & Definition	It would be helpful for bidders to know if the MCOs have a common format for transmitting prior authorizations or if there are multiple formats. Multiple formats require additional	There are multiple formats for transmitting PA information. The Contractor must plan for the receipt of PA information as part of their implementation plan. The successful Contractor will have

Question Number	Section/ Question	Comment	Response
	Page 11	programming and therefore have a potential impact on pricing.	the opportunity to meet with each MCO for specifications.
9.	Section 1 Purpose & Definition Page 11	Regarding the transition of recipients between fee-for-service and MCOs we're asking for a clarification. The purpose of the contractor receiving the PA from the MCO, and the intended use of it. And if the contractor accepts PAs, prior authorization numbers, from the MCO -- deems that that is a medically unnecessary service, or as determined by DMAS quality review or other means, is the contractor responsible for that PA determination, or is that determination responsibility sent back to the MCO who provided the original?	The Contractor shall honor authorizations for medically necessary services as determined by the MCO. The Contractor may subsequently request additional information from the provider if needed and perform a secondary review. This process also applies to PA information going from the Contractor to the MCO.
10.	Section 1 Purpose & Definition Page 11	Does the Department have a specific requirement as to the method/format that data will be transmitted between the Contractor and a MCO? What is meant by the term "honor MCO PAs?" Will the form and format be the same across all MCOs? How are these PAs to be transmitted to First Health?	No. See response to question 9. See response to question 8. MCOs have no interface with VAMMIS. It will be the Contractor's responsibility to ensure the information is entered into VAMMIS.
11.	Section 1 Purpose & Definition Page 11	The RFP indicates that Region 6 will be phased in the summer of 2005 and that MEDALLION and FAMIS change at that point. Should we be quoting Region 6 for services, given this change? But 6 and 7 should not?	No. Region 6 went live in September. Region 7, Winchester, will be completed by the time this contract is signed. Note a change in Region 4 – it will not be implemented May 2006. The earliest it will be is September 2006. Contractors should factor this into their bid.
12.	Section 2 Background page 17	The last paragraph states that "In addition, DMAS implemented new prior authorization requirements for Non-Emergency Outpatient MRI/CAT/PET Scans." Can the Department provide volumes for Non-Emergency Outpatient MRI/CAT/PET Scans for 2002 and 2003?	MRI/CAT/PET Scan review was started in August 2003. For the 5 month period, August 1, 2003 to December 31, 2003, there were: 6,749 reviews completed with 5,831 approved, 227 not approved, 379 referred for secondary higher level review by the supervisor and 312 referred for higher level review by the physician consultant. At supervisor level, 62% were approved and 38% were not approved. At the physician consultant level, 94% were approved, and 6% were not approved. During this 5 month period, there were 11,813 calls received, including inquiry calls due to the newness of the program during this timeframe.
13.	Section 2 Background Page 17	The State references an August, 2005 report from DMAS on ways to make the Prior Authorization process for outpatient rehab, home health, and outpatient psychiatric services more efficient. Is this report available to bidders, and if so, how can we access it?	The report is available on the DMAS web site under Studies and Reports or at the following link: http://www.dmas.virginia.gov/downloads/studies_reports/2005-RD116.pdf Based on recent meetings, held subsequent to the release of the RFP, the Department will issue an addendum to this report.
14.	Section 3	The RFP states that prior authorization for Out of State Services	Addendum 1 clarifies this to be: The Contractor shall be

Question Number	Section/ Question	Comment	Response
	Scope of Services Page 18	will be processed by Medical Support. Is this inclusive of all Out of State Services?	responsible for the provision of out of state services. DMAS shall be responsible for the end decision should the Contractor require a higher level review for any out of state services or costs negotiations.
15.	Section 3.2.3 Tasks Page 19	Who will be making PA requests: Providers and other caregivers, legal guardians, patients or all of the above?	Providers who provide direct service or those persons authorized by DMAS to approve services.
16.	Section 3.2.6 Tasks Page 19	In what format will DMAS transmit provider and recipient eligibility information? Does the Department intend to provide an entire eligibility file at the beginning of the new contract period? How frequently will this information be transmitted to the contractor once the new project period commences?	Please reference sections 4.15 and 4.16 of the RFP. As stated in sections 4.15.2, 4.15.3, and 4.15.4, all initial full files will be available during the implementation phase and will be updated or replaced on various cycles, based on the type of data. The format of the files to be transferred to the new Contractor has not been developed at this time as this will be a task to be accomplished during the implementation phase.
17.	Section 3.2.8 Tasks Page 19	States that "Requests that are denied for not meeting medical criteria shall automatically be sent to the Contractor's medical staff for reconsideration." However 12VAC 30-50-100 A.4.b states, "... the provider must request a reconsideration." Please clarify if the reconsideration process is automatically activated based on a nurses decision that the case does not meet medical criteria.	The reconsideration process is an automatic process.
18.	Section 3.2.8 Tasks Page 19	The task described in Section 3.2.8, requires denials to be sent to the contractor's medical staff or DMAS for reconsideration. Does this encompass all denials, including technical denials and denials for items with concise approval guidelines such as DME?	Section 3.2.8 requires the Contractor to approve or deny the PA request. Requests that are denied for not meeting medical criteria shall automatically be sent to the Contractor's medical staff for reconsideration. This includes all denials.
19.	Section 3.2.11 Tasks Page 19	Please clarify the extent (sampling; frequency; media etc) that DMAS is requesting for annual participant and provider satisfaction surveys?	Surveys shall be conducted annually.
20.	Section 3.2.12 Tasks Page 19	Specific examples of the level and intensity of interaction expected—or the minimum required—would help bidders appropriately staff for this interface with community entities.	The Contractor may have frequent contact with some groups, such as those providing waiver services. Other groups will have less frequency of interaction.
21.	Section 3.3 Mandatory Specifications Page 20	Please clarify whether the bidders must be a QIO, or if they can be QIO-like.	The Department prefers that qualified vendors meet the requirements, as defined by Federal regulations (42 CFR Part 475), as a designated Quality Improvement Organization (QIO) formerly known as Peer Review Organization (PRO) or QIO-like entity. Vendors that qualify as a QIO or QIO-like entity shall submit certification of their QIO status and will receive a proportionately higher score than those who do not qualify as this type of organization.
22.	Section 3.3 Mandatory Program	Please elaborate (or specify) on the source or type of independent evaluation or annual quality review that may be acceptable to DMAS	The Department presumes that any organization focused on quality review shall have as part of its strategic quality plan, an independent evaluation or an annual quality review.

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	Specification Page 20		
23.	Section 4 Technical Proposal Requirements Page 20	The scope of work requests evidence of how certain tasks are performed in current contracts. Will a bid be deemed viable if all tasks are not being performed in a current contract of the bidder?	Yes. We assume that very few bidders would have experience in all of these different services, since the services are so unique
24.	Section 4 Technical Proposal Requirements Page 21	One of the technical requirements cited in this Section requires the Contractor to develop a process for capturing all prior authorization activity in VAMMIS." Please elaborate/more fully explain what specifically the Department will require. For example, does this mean that the Contractor will simply be required to just enter the initial PA or is there more involved/required? "All prior authorization activity", is a very broad statement.	The Contractor is expected to approve or deny PA requests as received based on DMAS' policy and rules. These PA requests are transmitted to the VAMMIS and responses are to be returned back to the Contractor. The responses would be considered capturing "All prior authorization activity".
25.	Section 4 Technical Proposal Requirements Page 21	One of the technical requirements cited in this Section requires the Contractor's automated functions to interface with other systems. What are all the systems a Contractor must interface with…. will the Contractor be required to develop computer interfaces within the Department, other business associates/vendors, etc.?	The systems a Contractor must interface with would be, for example, a utilization management application using national criteria for PA service review (i.e., InterQual). Additionally as stated in Section 4.16, the Contractor is required to have computer interfaces with DMAS and its Fiscal Agent, First Health Services Corporation.
26.	Section 4.2 Traditional PA Services Page 21	Please elaborate/more fully explain the Department's expectation that the Contractor "post all related criteria available on the internet site that is required by this RFP"? Several national vendors of review criteria do not allow (a condition of their Licensing Agreements) their criteria to be publicly posted. How does the Department envision this dilemma being resolved?	The Department is aware of licensing agreements and issues related to those agreements. In such cases, it will be up to the Contractor, as part of their response to the RFP, to indicate how they will ensure providers have access to criteria for each of the services listed in this RFP.
27.	Section 4.2 Traditional PA Services Page 21	There are several services within this section that specify changes in service limits allowed by policy that will take place at a later time.	DMAS conducted a study for PA services that is on the DMAS web site at http://www.dmas.virginia.gov/downloads/studies_reports/2005-RD116.pdf The study recommended that DMAS move from five visits to one before requiring a PA. As a result of follow-up meetings held recently, the changes will be as follows: For home health services, Medicaid will pay for five visits per person per fiscal year before a prior authorization is required. For outpatient rehabilitation services, Medicaid will pay for five visits per person per fiscal year before a prior authorization is required For outpatient psychiatric services, the limit will go back to where it was four years ago, to twenty-six visits. Based on recent

Question Number	Section/ Question	Comment	Response
			meetings, held subsequent to the release of the RFP, the Department will issue an addendum to this report.
28.	Section 4.2 Traditional PA Services Page 21	Are those three the only changes, Home Health care, Outpatient Rehab, and Outpatient Psych	No. In-Home Intensive will not require a PA, but ask for concurrent review.
29.	Section 4.2 Traditional PA Services Page 21	When discussing the PA process throughout the RFP, several areas state, "Within X (a given number) of hours of admission …" Please clarify that the time frames for submission of the PA request or notification as related to the PA process are prior to the admission unless otherwise stated. If not, please clarify, per service, which timeframes are preadmission and those which are applicable after admission.	Inpatient services must be preauthorized within one working day of admission. The RFP does not specify that for Inpatient Psych services, but the same is true. This information is also in the manuals and regulatory sites provided under each service. For Intensive Rehab, the providers must request PA within 72 hours of admission. Home Health and Outpatient Rehab is prior to services outside of available service limits being rendered. DME is prior to the item being delivered. MRI/CAT/PET scans require PA prior to the service being rendered. Retroactive eligibility always poses an exception to these rules and retrospective review will be done. The other services have timeframes by which preauthorization must be requested following admission or in the case of waivers, following determination of eligibility for the waiver and start of services and all these requirements are spelled out in manuals and regulation.
30.	Section 4.2.1 Inpatient Hospital Medical/Surgical Services Page 22	Please clarify that concurrent reviews for inpatient medical necessity are only required for Length of Stays greater than seven days, or DRG outliers?	Concurrent reviews are required for both length of stays greater than seven days, DRG outliers and NICUs.
31.	Section 4.2.1 Inpatient Hospital Medical/Surgical Services Page 22	Could the Department expand/elaborate on its concurrent review requirement for inpatient hospital services? There appears to be some inconsistency in this section. For example, paragraph 1 pg. 20 states, "The length of say is not a factor in this authorization process." Paragraph 3 states, "… lengths of stay beyond seven days or DRG outliers requires concurrent review…." These conditions/ situations seem contradictory. Will the Department require the vendor to do concurrent review on all cases with a LOS in excess of seven days? How is the vendor to know if/when this threshold is reached? How does the Department envision the vendor will have access to DRG outlier information during a hospital stay?	The Department is requiring the Contractor to manage these cases. Yes. It is up to the Contractor, as part of their response to this RFP, to provide information on how they will determine the threshold. The Department assumes that the Contractor shall have familiarity with DRGs and with admission diagnosis.

Question Number	Section/ Question	Comment	Response
		Would the Department consider a retrospective review of cases that exceed the DRG outlier? These reviews could be scheduled on a monthly/quarterly basis.	No. The Department is concerned with the quality of care to the patient. Retrospective review of cases shall be handled via the DMAS UR process.
32.	Section 4.2.1 Inpatient Hospital Medical/Surgical Services Page 22	The RFP states that DMAS reimburses in-hospital med.surg by DRGs and LOS is not a factor. However, the RFP later states that DMAS requires concurrent reviews for LOS > seven days or DRG outliers, and reviews continue until discharge of patient. Then the next paragraph says that in 2005 DMAS had 21,000 claims for payment days of eight days or greater. So, if DMAS does not pay, and LOS is not a factor, why perform concurrent review and why would providers submit claims?	Concurrent review involves monitoring the medical treatment and progress toward recovery, once a patient is admitted to a hospital, to assure timely delivery of services and to confirm the necessity of continued inpatient care. If a preauthorization was obtained and the patient remains hospitalized beyond the initial approved date, the facility will be required to contact the Contractor. Concurrent reviews are required for both length of stays greater than seven days, DRG outliers and NICUs.
33.	Section 4.2.1 Inpatient Hospital Medical/Surgical Services Page 22	Can the department provide the number of DRG outlier payments made for Inpatient Hospital admissions in 2004?	The Department cannot provide the number of DRG outlier payments made for Inpatient Hospital admissions in 2004 at this time.
34.	Section 4.2.1 Inpatient Hospital Medical/Surgical Services Page 22	Please elaborate on the extent, scope and nature of the work you require the Contractor to perform related to "assisting with and coordinating discharge planning to assist recipients in making the transition from the hospital to an alternative level of care. This could be an extremely extensive and expensive piece of work.	Discharge planning is not required for all patients admitted to the hospital. Discharge planning should be dependent upon the diagnosis and severity.
35.	Section 4.2.1 Inpatient Hospital Medical/Surgical Services Page 22	"The Contractor shall be responsible for assisting with and coordinating discharge planning to assist recipients in making the transition from the hospital to the client's home, a skilled nursing facility, home health services, or into a HCB waiver program." Based on this language, is DMAS asking the Contractor to serve as a Case/Care Manager? Is DMAS expecting the Contractor to provide the actual service to the recipient or is DMAS requesting that the Contractor regulate the provider to make sure that this indeed happens? Will the state please further define the level and type of discharge planning coordination or case management activities that they expect from the contractor? Will the state please provide estimates as to the anticipated monthly volume of this discharge planning activity to ensure that all potential bidders are pricing the same level of service?	The Department is requiring the Contractor to manage these cases. The Contractor, in response to this RFP, should indicate its method for discharge planning. See response to question 31. The Contractor should refer to the volumes provided for home health and waiver services for an estimate volume.
36.	Section 4.2.1 Inpatient Hospital Medical/Surgical Services Page 22	Could the Department provide a little more detail on what it is looking for related to streamlining the "maternity admissions process" since PAs are not routinely done for ob admissions. Please define the current maternity admission process and	The Department is requiring a review of any maternity admission beyond 3 days and anything above a normal baby, i.e., all NICUs must be reviewed. For FY2005, DMAS had approximate 92,000 Inpatient hospital

Question Number	Section/ Question	Comment	Response
		provide the current maternity volume.	claims. Approximately 21,000 were for payment days of eight or greater; approximately 13,985 (15%) were OB claims. See Medicaid memos in Exhibit 4.
37.	4.2.1 Inpatient Hospital Medical/Surgical Services, page 22	The forth paragraph states that "Volume: For FY2005, DMAS had approximately 92,000 Inpatient hospital claims." Are these FY2005 year-to-date volumes, or are these FY2004 volumes?	FY 2005 year to date volumes.
38.	Section 4.2.1.c Inpatient Hospital Medical/Surgical Services Page 22	Handle DRGs and outliers in hospital contract, What is meant by "contract" in this context?	Delete the word "contract"
39.	Section 4.2.2 Inpatient Psychiatric Services p. 22	Recognizing that the duration of an authorization is dependent on the clinical condition of the member, has DMAS established typical authorization periods? Shorter authorization periods may require additional reviews and staffing, and thus have a potential impact on pricing.	The Department is looking to the Contractor's experience and criteria to address authorization periods.
40.	Section 4.2.3 (CORF) Page 23	Please confirm that Comprehensive Outpatient Rehabilitation Facility Services are to be classified as inpatient reviews as there are facilities outside of the hospital environment that provide CORF services.	CORF reviews are to meet the same criteria to determine medical necessity of treatment as is used for Inpatient Rehabilitation Reviews. Currently this is InterQual Rehabilitation Criteria.
41.	Section 4.2.4 DME Page 23	Regarding the State Plan services for DME as distinguished from technology waiver, is the State Plan service for DME a part of the scope of work?	Yes, state plan service for DME is part of the scope of work of this contract. NOTE: Hearing aids for individuals under the age of 21 will be covered under the State Plan. The Contractor shall prior authorize all hearing aids beyond the analog or digital aids. Documentation for PA shall include the physician order.
42.	Sections 4.2.5; 4.2.6; and 4.27 Outpatient Home Health, Rehabilitation, and Psychiatric Services Page 24	This section discusses a modification in service limits When does DMAS anticipate the limit modification to go into effect? Are there any other regulatory modifications that will affect the Contractor for this service? Please clarify who the provider is in this service arena. Is the provider the Home Health agency or can it also be the PT, OT and ST in addition to the Home Health Agency?	As a result of recent meetings, there will be no changes to outpatient home health and rehabilitation services. For outpatient psychiatric services, the limit will go back to where it was four years ago, to twenty-six visits. Home Health service providers are agencies that provide for skilled nursing services and can also provide for PT, OT, and ST in the home setting.
43.	Sections 4.2.5; 4.2.6; and 4.27 Outpatient Home Health, Rehabilitation, and Psychiatric Services	Please provide an estimate of the change in the numbers of prior authorizations that the proposed changes in authorization requirements for Outpatient Home Health, Outpatient Rehab Services and Outpatient Psychiatric Services are anticipated to generate?	As a result of recent meetings, there will be no changes to outpatient home health and rehabilitation services. For outpatient psychiatric services, the limit will go back to where it was four years ago, to twenty-six visits.

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<tr><th>Question Number</th><th>Section/ Question</th><th>Comment</th><th>Response</th></tr>
<tr><td></td><td>Page 24</td><td></td><td></td></tr>
<tr><td>44.</td><td>Section 4.2.7 Outpatient Psychiatric Services Page 24</td><td>Will all individuals who have previously received outpatient psychiatric services be considered to be beyond their first year of treatment? How will these individuals be identified?</td><td>The first day that a treatment is billed to Medicaid will begin the treatment year. Anyone still within the first year from the first billed day will be considered in the first year of treatment. The vendor will use the MMIS ARS system. This is a communication process with the MMIS that can show the service limits used for the outpatient psychiatric services for individual recipients/providers combinations.</td></tr>
<tr><td>45.</td><td>Section 4.2.8 Non-Emergency, Outpatient MRI/CAT/PET Scans Page 24</td><td>Will scan requests that are not addressed by InterQual criteria be reviewed by a DMAS physician or the contractor’s physician?</td><td>They shall be reviewed by the Contractor’s physician first.</td></tr>
<tr><td>46.</td><td>Section 4.2.9 EPSDT Page 25</td><td>Describe DMAS' expectations around outreach, care coordination and health services provided under the EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program.</td><td>DMAS shall be responsible for outreach, care coordination and health services provided under the EPSDT.</td></tr>
<tr><td>47.</td><td>Section 4.2.9 EPSDT Page 25</td><td>What is the estimated volume of EPSDT cases?</td><td>The data we have is strictly for durable medical equipment (DME) which seems to be the area that receives most requests to use EPSDT criteria. For calendar year 2004, 10,439 DME requests were received for individuals under 21. Of those, 774 required an EPSDT medical necessity review.</td></tr>
<tr><td>48.</td><td>Section 4.2.9 EPSDT Page 25</td><td>“Provide statistics for these services.” Please clarify what level/degree and frequency of the “statistics” the contractor will be required to provide under the EPSDT reviews.</td><td>As indicated in Section 4.2.9, the Contractor as part of their response to this RFP, shall provide statistics for these services. This would include the type and frequency.</td></tr>
<tr><td>49.</td><td>Section 4.2.9 EPSDT Page 25</td><td>Please clarify that the only cases that are reviewed for EPSDT are those for children under the age of 21 that do not meet medically necessarily criteria for prior authorization for other services.</td><td>Yes, this is correct.</td></tr>
<tr><td>50.</td><td>Section 4.3 Medicaid Specific Services Page 25</td><td>Throughout this section information is presented by Waiver program/ type of service. In some instances the Department reports the number of individuals receiving services by type of waiver, in some instances the number of PAs requested. Information is not consistently provided. Would the Department provide its best estimate of the number of beneficiaries for each waiver program/service and its best estimate of the number of PAs issued or projected for each waiver program/service referenced in Section 4.3?</td><td>The number of beneficiaries in each waiver program is identified in the response to question 62. The best estimate of the number of PAs for each service is as follows:
<table>
<tr><td>Elderly & Disabled</td><td></td></tr>
<tr><td>Personal Care</td><td>15,240</td></tr>
<tr><td>Supervision</td><td>1,700</td></tr>
<tr><td>Adult Day Hlth Care</td><td>600</td></tr>
<tr><td>Respite Care</td><td>5,300</td></tr>
<tr><td>PERS</td><td>1,340</td></tr>
<tr><td>CD-PAS</td><td>700</td></tr>
<tr><td>AIDS Waiver</td><td></td></tr>
<tr><td>Personal Care</td><td>120</td></tr>
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			Respite Care 31 Private Duty Nursing 10 Supervision 10 Nutr Supplements 180 Case Management 170 Attendant Care 10 CD-Respite 1 DD Waiver Adult Day Companion 10 Assistive Technology 120 Attendant Care 270 CD-Respite 220 Companion Services 0 Crisis Intervention 10 Crisis Supervision 10 Day Support 50 Environ Modifications 90 Family/Caregiver Trng 90 In-Home Res Support 200 Personal Care 70 PERS 50 Pre-vocational Services 0 Respite Care 50 Skilled Nursing 13 Support Employment 5 Therapeutic Consult 130 **Tech Waiver - DME** **4,572**
51.	Section 4.3 Medicaid Specific Services Page 25	The term “case management” has a variety of meanings in different delivery systems. It would be helpful if DMAS would specify more clearly what is expected—or what is the minimum service required—in terms of case management for this contract.	DMAS is not prescribing the service to be included in case management. The Contractor, as part of their response to this RFP, shall propose what is offered under case management.
52.	Section 4.3 Medicaid Specific Services Page 25	Is there a regulatory tool for HCB on-site reviews currently in use by the Commonwealth? If yes, can a copy be provided?	The RFP requires the Contractor to create an instrument to be utilized for on site reviews.

Question Number	Section/ Question	Comment	Response
53.	Section 4.3.1 Residential Psychiatric Treatment Services Page 26	Please distinguish the differences among concurrent review, desk review and on-site review?	These are common terms in the health care and quality industry.
54.	Section 4.3.1 Residential Psychiatric Treatment Services Page 26	Please provide the number and geographic distribution for the on-site reviews of the Residential treatment facilities?	The Department is not prescribing the number or distribution of on-site reviews. The Contractor, as part of their response to this RFP, shall propose the method and number of on-site reviews.
55.	Section 4.3.1 Residential Psychiatric Treatment Services Page 26	What volume/percentage of RTC facilities will require on-site reviews annually? Do RTC reviews include the RTC step-down programs and if so will on-site reviews be required? What is the projected volume of on-site reviews?	See response to question 49. See response to question 49.
56.	Section 4.3.3 Intensive In-Home Services Page 26	The RFP states "these services are not currently part of the PA process under the current contractor." Please clarify whether or not DMAS requires the new contractor to pre-authorize intensive in-home services. How is the pre-authorization process for these services currently managed?	See Addendum 1 dated October 12, 2005. The Contractor shall not provide for prior authorization of these services, however, the Contractor shall manage and provide for concurrent review, desk review and on site reviews as appropriate.
57.	Section 4.3.3 Intensive In-Home Services Page 26	Section discusses a modification in service limits and indicates that these services are not currently a part of the PA process under the current contractor. When does DMAS anticipate the limit modification to go into effect? Are there any other regulatory modifications that will affect the Contractor for this service? Has DMAS been processing the PA's for this service?	See response to question 54.
58.	Section 4.3.4 HCBW Page 27	Please provide copies of the five HCBW waivers for which the contractor will be conducting prior authorizations and/or utilization review.	Copies of the manuals for each waiver may be downloaded from the DMAS web, www.dmas.virginia.gov. Click on Provider Manuals, then on the specific manual. Regulatory sites for the waivers are identified under section 4.3.4 in the RFP.
59.	Section 4.3.4 HCBW Page 27	If DMAS requires the review of treatment plans and other documentation as part of the authorization of HCBW services, it would be helpful to provide an estimate of the material providers must submit. This may affect estimates of time/staff required to perform the reviews and also may impact the design of systems to accept requests for authorization	It is up to the Contractor to propose the method for providers to submit information that DMAS requires. See the provider manuals on line for DMAS' requirements for each waiver enrollment/service.
60.	Section 4.3.4 HCBW Page 27	Under Home and Community Based Waiver populations, what is the distinction between medical and psychiatric in terms of where the service is managed? (ie. Alzheimer's waiver; AIDS waiver, each of which have a medical and behavior / mental	There is no distinction between medical and psychiatric in terms of where the service is managed.

Question Number	Section/ Question	Comment	Response
		health component)?	
61.	Section 4.3.4 HCBW Page 27	In the case of a waiver decision made by an external agency/organization, who would continue to determine waiver eligibility - Contractor or State?	DMAS would make this determination for enrollment eligibility. The Contractor reviews for continued service authorization.
62.	Section 4.3.4 HCBW Page 27	The contractor is responsible for enrolling individuals in all the waivers stated. How many individuals enrolled in these waivers during each of the last fiscal year and two preceding years? In what system(s) (the prior authorization system and/or the MMIS system) would the Department like to have enrollment in these services documented?	According to *The Statistical Record of the Virginia Medicaid Program:* Elderly & Disabled Waiver FY 2002 – 9,658 (304 were new enrollees) FY 2003 – 9,950 (292 were new enrollees) FY 2004 – 10,533 (583 were new enrollees) CDPAS Waiver FY 2002 - 199 (48 were new enrollees) FY 2003 - 162 (37 were new enrollees) FY 2004 - 417 (255 were new enrollees) AIDS Waiver FY 2002 – 337 (80 were new enrollees) FY 2003 – 277 (60 were new enrollees) FY 2004 – 274 (3 new enrollees) IFDDS Waiver *DMAS enrolls FY 2002 – 124 (110 were new enrollees) FY 2003 – 241 (117 were new enrollees) FY 2004 – 270 (29 were new enrollees) Tech Waiver *DMAS enrolls FY 2002 – 308 (28 were new enrollees) FY 2003 – 337 (29 were new enrollees) FY 2004 340 (3 were new enrollees) DMAS' MMIS system is our PA system as well as our claims system. The Contractor must enter enrollment and service decisions in the MMIS. Supporting documentation must be in the Contractor's database.
63.	Section 4.3.4.e Alzheimer's Waiver Page 28	What waiver services will be provided under this new waiver?	There are no services to authorize under the Alzheimer's Waiver. The Contractor shall provide authorization for placement into qualified Assisted Living Providers.
64.	Section 4.3.4.f Background Page 29	What percentage of the PAS is referred for specialized services and for a Level II?	For FY 2005, there were 5,194 Level 2s performed for EDCD Waiver and 40 Level 2s performed for HIV/AIDS Waiver individuals.

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65.	Section 4.3.4.f Background Page 29	We suggest using one Contractor to perform preadmission screening, Level 1 and Level II, to improve coordination of services.	Thank you for this suggestion.
66.	Section 4.3.4.f Background Page 29	Does this section apply to the Individual and Family Developmental Disabilities Support Waiver only or all waiver programs?	The preadmission screening process is a requirement for all individuals in all waivers. The PAS Teams for EDCD and AIDS Waivers are the local department of social services and the local health department. The PAS Teams for these waivers determine if the individual meets nursing facility criteria. For the IFDDS Waiver, the PAS Teams are the Child Development Clinics. The CDCs determine if the individual meets ICF/MR criteria as the alternate institutional placement. DMAS performs the PAS for Tech Waiver.
67.	Section 4.3.4 g Levels of Care Designation for Personal Care Services Page 29	Please clarify if this section pertains to all waiver programs in which personal care services are allowed.	Yes, this pertains to personal care services across all waivers that include personal care as a service.
68.	Section 4.3.4.h Contractor Responsibilities Page 30	The RFP states: "Prior authorize the number of service hours, based on an algorithm developed by DMAS, for the activities of daily living (ADLs), the instrumental activities of daily living (IADL), and medical nursing needs, to determine number of hours for each individual. The Contractor shall have the ability to collect, track and report information." Is the algorithm currently developed and in use by the current contractor? If so, can DMAS provide more specifics on the description of the algorithm. If not, when will DMAS anticipate the algorithm be available?	No, DMAS has not yet developed an algorithm.
69.	Section 4.3.4.h Contractor Responsibilities Page 30	"Assist DMAS in the provision of training for PAS and CDC teams, service facilitators and providers." Please define the specific responsibilities of the contractor in assisting DMAS in the provision of training. Will the Contractor be responsible for developing and producing materials, attending and presenting training materials? What are the frequency, duration and location of the training for these groups?	The Contractor will be responsible to prepare information regarding their preauthorization process to the providers. The Contractor will be responsible for developing and producing materials, attending and presenting training materials. DMAS must approve all training materials prior to producing and presenting material. The duration of each training will not exceed 1 day. The frequency will vary, and should not exceed 6 per year; the locations will be statewide.
70.	Section 4.3.4.i Utilization Review Page 30	States that "Interested Offerors must submit this RFP, through a separate cost proposal, a process for Utilization Review of HCB waiver services. The review shall include an on-site review of a ten percent sample of HCB waiver providers, including PAS teams and CDCs…" Should the prior authorization piece (29,700 reviews, per page 36) of HCB Waiver Services be priced under the Prior Auth Cost Sheet (Attachment XII)? Should the	The prior authorization of HCB Waiver service should be priced under the Prior Auth Cost Sheet. The on-site HCB waiver reviews should be the only service priced on the Utilization Review Services Cost Sheet. The 10% sample is for each provider being reviewed. Example:

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		On-Site HCB Waiver Reviews (10% sample - including PAS teams & CDCs) be the only service priced on the Utilization Review Services Cost Sheet (Attachment XII)? Is the estimated case volume for the On-Site HCB Waiver Reviews 2,970 (10% of 29,700 Community Based Care Prior Auth Requests that are listed in Section 4.5 Estimated Volume of PA Requests on Page 36)?	if one provider has 100 waiver recipients, 10% of the 100 recipients would include 10 records for review.
71.	Section 4.3.4.i Utilization Review Page 30	Please define the term "Utilization Review"; we want to make sure we are submitting a response that addresses the Department's specific requirement/expectation.	Utilization Review is defined as methods and procedures to safeguard against unnecessary utilization of care and services. It includes reviewing medical necessity criteria, determining if criteria is met for the service; to determine if providers are qualified to render services. The purpose of utilization review (UR) is to determine whether services delivered were appropriate, whether services continue to be needed, and the amount and kind of services required. Utilization review is mandated to ensure that the health, safety, and welfare of the recipients are protected and to assess the quality, appropriateness, level, and cost-effectiveness of care; to ensure quality of services is being provided and to give providers feedback and technical assistance, and to recognize and collect overpayment of reimbursements from DMAS due to violation of regulations. DMAS will collect all overpayments.
72.	Section 4.3.4.i Utilization Review Page 30	Please provide the total number of HCB waiver services providers.	For the waivers under this RFP, there are 2,416 providers.
73.	Section 4.4.6 Responsibilities Page 32	Describe the scope of responsibilities for the CSA Medicaid population and the CSA Non-Medicaid population. Please detail the contractor reimbursement for the CSA Medicaid population. What is the difference in services between these two populations?	All of Section 4.4 Comprehensive Services Act refers to a program that is separate from Medicaid. It pertains only to those children whose placements in licensed residential treatment facilities and group homes are funded through CSA, and who do not receive any reimbursement for their residential stay from Medicaid. Regarding the scope of responsibilities, the Contractor will review the placement, services provided, length of stay and discharge planning for CSA children. The Contractor will provide specific feedback to the CPMT, or its designee, to allow sound utilization management decisions on the most appropriate and effective care of individual children and their families. The specific review process will be developed in partnership with the Contractor, OCS, and the users group comprised of representatives from local governments that choose

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			to participate in the program. OCS would like the contract agent to propose ideas for the review process based on the information provided in Section 4.4. Reimbursement for the work of the CSA-UM program is $175,000. There are two programs delineated in this RFP for residential services. This one is non-Medicaid, and the Medicaid program is described in section 4.3.1.
74.	Section 4.4.7 Volume of Cases for Review Page 32	Please clarify that "an average of 72 localities have voluntarily entered into an inter-agency agreement with DMAS to perform utilization review of these services…" Please elaborate. Does this mean that the 72 localities are performing their own utilization review or does it reflect that they have agreed to the utilization review process set forth by DMAS?	Section 4.4 Comprehensive Services Act refers to a program that is separate from Medicaid. This Section 4.4 of the RFP contract will be managed and monitored by OCS. There are 73 localities that have been given the option to participate. However, it is not likely that all 73 will participate. The localities that choose to participate will each have their own local utilization review process for children who are receiving CSA services other than residential care. The Contractor will only be responsible for conducting reviews on children placed in residential facilities (see Section 4.4.8 to see a description of the types of residential facilities). The review process will not be developed by DMAS. A uniform review process for CSA reviews will be developed in partnership with OCS, the Contractor, and the participating localities. Localities will then have an opportunity to enter into an agreement with OCS to participate in this program. The Contractor will then know the specific localities that are participating for the year.
75.	Section 4.4.10 Training Page 33	"The Contractor's reviewers will be trained on CSA, the use of CAFAS and the Decision Support Guidelines/Level of Need Chart." Please clarify when the training for the Contractor's reviewers will be conducted, and who will be providing the training on CSA, the use of CAFAS and the Decision Support Guidelines/Level of Need Chart. What will be the duration and location of training?	Training for the Contractor will be coordinated by OCS in partnership with the Contractor. OCS will be flexible in working with the Contractor on the timing and implementation of the training. The purpose is to ensure reviewers are trained before they start conducting reviews. The training may be provided by OCS, state agency staff, local governments, and a trained CAFAS trainer. The location will be in central Virginia (Richmond or Charlottesville) and the duration will be 1 to 1.5 days.
76.	Section 4.4.11 Review Process Page 34	For these services, as well as others in which providers/teams are to submit documentation, it would be helpful to know if a standard format has been established for the required information or if each provider/team/region designs their own. As noted above, the response will impact the way in which bidders staff and plan to accept the required information	OCS will work with participating local governments and the Contractor to develop one standard process and documentation for the reviews. However, feedback to local governments should be individualized and specific to the child being reviewed, i.e. as stated in the RFP, Section 4.4.11 "Emphasis of the reviews shall be on the unique strengths and needs of the child and family, the appropriateness and effectiveness of services provided in the placement, and the impact on child and family outcomes, rather than compliance with documentation."
77.	Section 4.5	Could we get FY 2005 review volumes or volumes from 1/1/05 –	Review Volumes from 1/1/05 – 6/30/05

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	Estimated Volume of PA Review Page 36	6/30/05?	Inpatient Acute: 24,538 Inpatient Psych: 6,776 Inpatient Rehab: 480 Home Health: 11,593 DME: 14,780 Outpatient Rehab: 9,969 Outpatient Scans: 8,668 RTS: 3,060 TFC-CM: 2,623 EDCD Waiver: 10,130 AIDS Waiver: 177 DD Waiver: 871
78.	Section 4.5 Estimated Volume of PA Review Page 36	Please provide the volumes of review currently received by transmission, i.e., telephone, fax, etc.	Inpt Acute: 17,238 Phone; 6,970 fax/paper Inpt. Psych: 6,099 Phone; 610 fax/paper Inpt. Rehab: 89 Phone; 387 fax/paper Home Health: 8,593 Phone; 2,913 fax/paper DME: 2,763 Phone; 11,594 fax/paper Outpt. Rehab 7,153 Phone; 2,569 fax/paper Outpt. Scans 8,668 Phone RTS: 3,060 fax/paper TFC-CM: 2,623 fax/paper EDCD Waiver: 35 Phone; 9,404fax/paper AIDS Waiver: 2 Phone; 170 fax/paper DD Waiver: 19 phone; 842 fax/paper
79.	Section 4.5 Estimated Volume of PA Review Page 36	There are several references to prior authorization volumes throughout the RFP, and this table as an example. We had difficulty -- there's a discrepancy between what's reported under some sub-sections and between what's on this table. And didn't know if there was going to be clarifications in volumes, particularly as it relates to cost center technology support that we're going to have to provide or anything like that.	The number on the Inpatient Hospital Services must be modified. DMAS has determined that the maternity volume is not included in the inpatient service volume number. Contractors should add in the maternity volume as indicated in Section 4.2.1. Inpatient Hospital Medical/Surgical Services
80.	Section 4.5 Estimated Volume of PA Review Page 36	Please provide the number of overturned and upheld reconsiderations and denials. Do the volumes reflected in the table include Medicare A or B eligibles or only Medicaid, FAMIS Plus, and FAMIS?	The volumes reflected in the table (Exhibit 1) should be considered as Medicaid, FAMIS Plus, and FAMIS recipients. There are some Medicare A or B eligibles included, but their inclusion is limited to cases in which Medicare has been exhausted or Medicare has denied coverage and Medicaid had become primary.
81.	Section 4.6 Review Process Page 36	For what reasons would the Contractor delay or suspend a PA authorization request?	A PA request could be suspended due to the need for additional medical information, for completed paperwork required for the particular program for which PA is being requested, also, the request could be suspended pending higher level of review by the supervisor or physician consultant.
82.	Section 4.8.1	This section states that “The Contractor is expected to verify	Yes, Section 4.8.1, 1st Paragraph, 3rd Sentence should read

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	Enrollment and Eligibility Verification Page 37	eligibility through the Contractor's access to The Department's VAMMIS……based on VAMMIS on-line eligibility information. Section 3.1.6 states "Eligibility information will be downloaded to the contractor. Are these sections saying 2 different things? This section states, "…that the enrollee is enrolled with the Contractor…". Is this correct or should the "Department" replace the term "Contractor"?	"…that the enrollee is enrolled with the Department…", whereas "Department" should replace the term "Contractor". These 2 sections are not in conflict as Section 3.2.6 (correct cite) states that the recipient eligibility will reside in the Contractor's system based on daily downloads, initial loads, and possibly an annual replacement. Section 4.8.1 further clarifies that the most recent recipient eligibility must be used by the Contractor and is derived by many ways in addition to initial load, either by daily requests using HIPAA compliant 270/271 transactions (cycles to be determined during the implementation phase), or by access to the VAMMIS Automated Response System (ARS) to verify the applicable eligibility in a real-time process that returns the most current eligibility information which also incorporates the 270/271 transactions processing.
83.	Section 4.8.1 Enrollment and Eligibility Verification Page 37	Last paragraph – What does this statement represent? The provision of enrollment and eligibility verification for all services?	This paragraph is stating that the Contractor must provide to eligible enrollees all services listed in the RFP and the final contract.
84.	Section 4.8.2 Disenrollment Page 38	Will contractor receive disenrollment from the Department or from the fiscal agent? How frequently will disenrollment be transmitted? Can the department share the current file format for disenrollment transactions if one exists?	The Contractor will not receive any disenrollment information from the VAMMIS. The Contractor could request eligibility information using the HIPAA compliant 270/271 transactions or could use the VAMMIS Automated Response System (ARS) to verify the applicable eligibility in a real-time process. These responses could be used to update the Contractor's eligibility information. An additional process that could be pursued during the implementation phases is the use of HIPAA compliant 834 transactions (Benefit Enrollment and Maintenance) associated with only terminated (canceled) recipients. This data would be generated by the VAMMIS and available for the Contractor's use.
85.	Section 4.8.2 Disenrollment Page 38	Last paragraph, last sentence "which invalidates the authorization". If an authorization period begins prior to disenrollment, is the entire authorization period invalid, or is only the portion from the disenrollment date on invalid?	Only the portion of the authorization period that is after the disenrollment date would be associated with lost eligibility and invalid eligibility.
86.	Section 4.8.4 Retrospective Reviews	What is the projected number of retrospective reviews by review type?	Retroactive eligibility determination is by far the biggest reason for the necessity of retrospective review. Otherwise, MCO enrollment and disenrollment could prompt the need for

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	Page 38		retrospective review. The Contractor must always honor authorizations for services issued by the MCO, so retrospective reviews in these cases is somewhat limited. Numbers of these reviews also vary based on the time of year and the provider's fiscal year end. By far, the largest volume of retrospective review is for inpatient hospitalizations, both medical and psychiatric, as well as intensive rehabilitation. Contractors should anticipate receiving an average of approximately 50 – 75 of these reviews per week. Most hospitals choose to send these reviews in to the Contractor on paper, rather than utilizing telephone or fax alternatives, though both may also be used by the provider to obtain retrospective authorization for services. NOTE: The figures provided are only a historical average, and Contractors must consider that the actual retrospective reviews received could be above or below the provided figures. Retroactive eligibility determination is frequently found in the Medicaid fee for service population. This fact, plus provider fiscal year ends contribute to the volumes of retrospective reviews received.
87.	Section 4.9.3 Provider Reconsideration Page 39	This section states, "the provider may accept that decision and the case will be denied and a denial letter identifying appeal rights will be generated. Is there an alternative other than appeal if the provider chooses to not "accept that decision"? Could the Department please clarify if the Contractor will be generating and sending decisions letters to the provider and recipient or if these letters will be generated by VAMMIS?	For inpatient services, all letters sent to the providers and enrollees are generated out of VAMMIS advising of their appeal rights. For outpatient services, including Home Health, DME, and Outpatient Rehabilitation, the first level of provider appeal is to the supervisor for reconsideration of the denial. The supervisor does issue an internal decision letter to the provider following his/her review. In this letter, the supervisor informs the provider of their appeal rights and states instructions for filing an appeal to DMAS Appeals Division.
88.	Section 4.9.4 Provider Appeals Page 39	If DMAS has established requirements or expectations about the credentials of Contractor staff who attend appeal hearings, it would be helpful to have those credentials stated so bidders may appropriately staff.	The Contractor, as part of their response to this RFP, shall propose staff to attend appeal hearings. DMAS has no established requirements, but the expectation of Contractor staff representing the agency in an appeal is that they have full understanding of the case specifics, reasons for denial, understanding of the agency's policies and procedures as they apply to the appealed service, and the ability to professionally represent both the contractor and DMAS at the hearing, both informal and formal. In addition, if testifying at a client appeal, staff should be able to discuss the case in layman's terms, so that the enrollee can understand the reasons for the denial decision.
89.	Section 4.9.4 Provider Appeals Page 39	Can the Department provide the number of appeals for 2004?	In 2004, there were 349 inpatient provider appeals (317 acute, 25 psych, 7 intensive rehab); 9 outpatient provider appeals (1 HH, 5 DME, 3 rehab); 245 behavioral health provider appeals (178 RTC, 67 TFC) and 15 CBC provider appeals. There were 30

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			NEOP (scans) provider appeals but no breakdown is available as to whether they are provider or recipient appeals.
90.	Section 4.9.4 Provider Appeals Page 39	This Section states in part, … "Failure to submit appeals summaries within the required timeframe shall result in Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance" Please describe the types of "costs" DMAS incurs. What is potential penalty for the Contractor?	If a provider appeal is lost due to the failure of the Contractor to submit their appeal summary within the required timeframe, the penalty to the contractor would be the actual cost of the billed service. Depending on the service involved, the costs would vary. For example, if the Contractor denied a specialized wheelchair for a patient that would cost the agency a total of $20,000 and the Contractor failed to submit their appeal summary to the appeals division within the required timeframe, the provider will automatically prevail in the appeal and the contractor would be assessed the cost of the wheelchair. Clearly, the example given would be a high end penalty, but is a realistic example.
91.	Section 4.10 Prior Authorization Processing Center Page 40	A small sample of Medicaid participating providers were surveyed for the purpose of establishing their hours of operation. The following provider types were contacted; CBC, Outpatient (home health, DME, Rehab), Hospitals (case management/ utilization review departments that are responsible for preauth) and BH. Only one hospital reported hours beyond 6:00 PM. The majority of the providers reported their workday ended between 4:30 and 5:00. We believe these results are reflective of the hours of operation for the vast majority of Medicaid providers. In light of these results would the Department consider modifying the hours of operation for the Processing Center from 8:00 a.m. – 7:00 p.m. to 8:00 a.m. – 5:00 p.m.? This schedule is in line with the Call Center/Help Line maintained by the Department and routine business/operating hours for most Medicaid providers. It would also represent a cost containment opportunity for the Department.	Thank you for your survey, however it is not reflective of the service level the Department wishes to provide to the provider community under this contract. The hours of operation as listed in the RFP shall stand.
92.	Section 4.10 Prior Authorization Processing Center Page 40	This Section states that the Department will define the Contractor's Holiday Schedule. Has this scheduled been defined? If no, when might it be defined? If it has been established, please provide the Holiday schedule acceptable to the Department	The State has several holidays where the Contractor will be required to remain open, such as Columbus Day.
93.	Section 4.10 Prior Authorization Processing Center Page 40	States that, "The Contractor agrees to relinquish ownership of the toll-free numbers upon contract termination, at which time the Department shall take title to these telephone numbers." Does that mean that the successful contractor will be taking over the incumbent's phone lines at the start of this contract?	No. The Contractor shall not take over the incumbent's phone number. The Department is requesting the establishment of a new toll-free number, as the contracts will be running concurrently for a short period of time.
94.	Section 4.10.1	Can you provide a breakdown on the types of calls into the call	Available breakdown for types of calls into the call center is

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	Estimation of Present Call Volume Page 40	center (i.e., prior authorizations, appeals, consumer questions, et al)?	limited to phone reviews completed and phone inquiries. There is no breakout for phone appeals and provider questions would come through as phone inquiries. Consumer questions are not handled by the PA phone center. Per review unit the PA calls and Inquiries are itemized below for the period January 1, 2005 through June 30, 2005: <u>PA Calls:</u> Inpatient Unit: 31,830 Outpatient Unit: 20,660 Outpatient Scans: 16,207 HCBW: 8,079 RTS/TFC-CM: 2,409 Note: These figures only reflect telephone requests and must be considered in that context. <u>Inquiry Calls:</u> Inpatient Unit: 12,500 Outpatient Unit: 5,781 (Includes Outpatient Scans) HCBW Waivers: 4,720 RTS/TFC-CM: 676
95.	Section 4.10.1 Estimation of Present Call Volume Page 40	What is the average call length for each service type?	<u>Review Lines:</u> Inpatient Acute: 10 mins. 52 sec. Inpatient Psych: 11 mins. 28 sec. Inpatient Rehab: 2 mins. 49 sec. Home Health: 9 mins. 41 sec. DME : 5 mins. 27 sec. Outpt. Rehab 5 mins. 27 sec. EDCD/AW 4 mins. 09 sec. RTS 2 mins. 00 sec. TFC-CM 2 mins. 23 sec. These average times reflect only the time on the phone calls and do not reflect wrap-up time needed to complete the PA, including completion of data entry. <u>Inquiry Lines :</u> Inpatient 1 mins. 55 sec. Outpatient 2 mins. 05 sec. EDCD/AW 1 mins. 42 sec. RTS/TFC-CM 2 mins. 11 sec.

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96.	Section 4.10.1 Estimation of Present Call Volume Page 40	What percentage of calls requires a translator/interpreter?	To date, the current contractor has not received any calls that required a translator/interpreter.
97.	Section 4.10.1 Estimation of Present Call Volume Page 40	Realizing that Section 4.10.1, page 40, represents data for PA requests made telephonically and not by any other method of submission, please clarify the following: Outpatient: the number of calls received 36,755. However, when compared to the numbers provided on page 36 of the total of all PA requests for outpatient services, all methods of submission and not including reconsideration and appeals, there is a wide disparity of numbers. The outpatient services included from page 36 are as follows: OP DME (21,448); Orthotics (2,650); OP Home Health (17,049); OP Rehab (16,736); and OP Psych (22,450). These services total 90,333. Understanding that a portion of the disparity may be from including a service or two in the count that may not be intended for the category, however, even if one or two services were removed a wide variance remains. Another possible explanation is that of method of submission, 53,578 PA requests would have been received either via mail, DDE, or email. Please clarify which is the case-are the numbers incorrect, and if so, what are the correct numbers; or if the numbers on pages 36 and 40 are correct, please indicate which method of submission other than calls had the highest volume. NEOP: the number of calls received is shown on page 40 as 29,060 as compared to the number of PA requests shown on page 36 as only 16,942 (this total includes reconsiderations and appeals). This leaves a deficit of 13,118 PA requests. In other words, the total of PA requests submitted via any method is 16,942, which is 13,118 less than the number of PA calls received (29,060) as reflected on page 40. These numbers do not support one another. Please confirm which number is correct.	The table of page 40 in Section 4.10.1 represents the number of calls received. These numbers cannot be compared to the table on page 36 in 4.5 which is the numbers of PA requests/reconsiderations/appeals handled in calendar year 2004. Vendors need to keep in mind that the number of requests reflects the number of PA line items requested, not just the number of overall requests. The number of calls received could include requests for PA, requests for status, callbacks in response to pended PA lines, call to verify if PA is required, etc. Therefore the disparity between the two tables is appropriate and accurate based on information stored in the current vendor's database.
98.	Section 4.10.3 The Contractor Shall Page 40	"Provide a sufficient number of properly functioning toll-free and V/TTY telephone numbers…" How many toll-free and V/TTY telephone numbers does the current contractor have in place?	The current Contractor has two toll-free phone lines and three toll-free fax lines. They do not have any V/TTY telephone numbers in place
99.	Section 4.10.3 The Contractor Shall	In the Department's description of the type of services the Contractor will be required to perform as part of the Processing Center's functionality, the Contractor is expected to; "… provide	The technical assistance anticipated includes such things as criteria, how to submit PAs, documentation, etc. Any PA Contractor should have technical staff the would be

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	Page 40	technical support functions for providers who request assistance on how to complete the PA." Does the technical support include assistance on completing HIPPA EDI transaction sets?	knowledgeable in the HIPAA 278 transaction sets (as these are CMS mandated) and has to interface with the providers whom want to submit them to ensure the PA Contractors system can accept from and send back to providers. DMAS will not assist in the design/testing with the PA contractor for this process.
100.	Section 4.10.3 The Contractor Shall Page 40	In order to assist a Contractor in fulfilling the performance requirements specified for the Processing Center, could the Department respond to the following questions related to the Help Line it maintains: • A list of languages expected to be available • Estimated volumes for TDD/TTY • Estimated volumes requiring special services (language interpretation, TDD/TTY) Are any graphs available showing call volumes by time of day?	To date, no estimated volumes are available as the current Contractor has not received any calls that required a translator/interpreter, or received any calls requiring the use of TDD/TYY special services. This is due in part to the fact that the current Contractor works solely with providers and therefore all of their calls are from providers. They currently do not handle calls from recipients, who typically are the ones who may need a translator or TDD/TYY special services. See the attached graphs (Exhibit 2) showing call volumes by time of day for the week of 9/26/05 - 9/30/05 by service unit.
101.	Section 4.11.2 Staffing Plan Page 43	Can the reviews be conducted by licensed health professionals, e.g., RHIAs, licensed clinical social workers, LPNs?	Yes, reviews may be completed by these professionals.
102.	Section 4.11.2 Staffing Plan Page 43	Under the Staffing Plan, does the agency require that Registered Nurses perform the review?	No, this is not a requirement.
103.	Section 4.11.2 Staffing Plan Page 43	Is there a specific license that is required, if you don't require a nurse.	In the RFP, we ask that you tell us the type of professionals that you're planning to use, as part of your proposal. DMAS not requiring an RN at the first level.
104.	Section 4.11.2 Staffing Plan Page 43	Not requiring an R.N. at the first level; is that for all services?	The Contractor, as part of their staffing response to this RFP, shall indicate the level and types of staff required for each service type.
105.	Section 4.11.2 Staffing Plan Page 43	Are physicians and clinical reviewers required to be Virginia-based?	This requirement was removed in the final draft of the RFP.
106.	Section 4.11.2 Staffing Plan Page 43	Will the Department entertain the use of PRN and part-time staff by the Contractor?	Yes, the RFP does allow for part time staff.
107.	Section 4.11.2.b.1 Staffing Plan Page 43	Please clarify what is meant by "This person shall be at the Contractor's officer level…" Is it the State's intention that the Project Director hold a certain title within the entire organization, such as chief operating officer?	No, this is not a requirement. However, the Project Director shall have the authority to make contract, operational, and profit and loss decisions.
108.	Section 4.11.2.b.4 Staffing Plan Page 44	Is a full-time and dedicated Medical Director required for this contract. What happens if the population decreases?	No. The Department requires a Medical Director who shall be responsible for ensuring that Virginia's process has priority. The Contractor should establish a back up for this position.
109.	Section	Does DMAS expect the full time Medical Director position to be	See response to question 98.

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	4.11.2.b.4 Staffing Plan Page 44	filled by a single individual or could the Vendor fulfill this requirement by engaging 2 part time physicians? Utilizing 2 part time physicians could increase the pool of available candidates, provide broader coverage for the program and could represent a more cost effective alternative.	
110.	Section 4.11.3 Licensure Page 45	Could the Department clarify/elaborate on the term "provider" used in this section? Will a Vendor be expected to assure that all Medicaid participating providers be legally authorized to provide services to Medicaid eligible beneficiaries?	No. Provider in this regard refers to the Contractor's staff.
111.	Section 4.12.3 Notice of Subcontractor Termination Page 45	States that "In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include at a minimum, information regarding how continuity of care will be maintained." Could you please explain what is meant by "continuity of care" as it relates to this requirement?	If the Contractor subcontracts any services, the Contractor shall be responsible for ensuring that services continue without disruption should there be a termination of the subcontractor.
112.	Section 4.13.1 Enrollee Grievance Page 46	Could the department clarify/elaborate on the expectations of an enrollee reconsideration process….as stated in 3.1.8 all denials must be sent to the Contractor's medical staff or DMAS for reconsideration. Is the Department requesting a second or additional level of reconsideration for enrollees?	There is no longer an enrollee consideration process under this RFP.
113.	Section 4.14.7 Transition Management Page 48	Please provide the coordination process for recipients transitioning between fee-for-service and managed care programs?	The Contractor, as part of the response to this RFP, shall provide the coordination process. Note: there is a 30 day window between a recipient's enrollment into Medicaid under fee-for-service and enrollment into an MCO. Conversely, if a recipient moves from an MCO to fee-for-service, the enrollment in fee-for-service is effective on the first day of the month.
114.	Section 4.15 VAMMIS Interface Requirements Page 48	This section describes a very cumbersome and complicated procedure to process HIPPA compliant 270/271/278 transactions. Why couldn't the Department require all HIPPA transactions sent by providers to be sent to the Fiscal agent, and then routed/referred to the Contractor as appropriate? The process specified by the Department seems to complicate an already complex/complicated procedure and will certainly confuse the provider community. Additionally, the Departments specifications will be a more costly/expensive alternative than the option proposed above. The Department's comment and explanation will be appreciated.	Currently, the VAMMIS is designed to receive all implemented HIPAA (correct cite) transactions; however the providers are not employing the 278 transaction. Most DMAS PA requests are received by the current Contractor as either Fax or telephonic transmissions. Additionally, paper PA requests are forwarded to DMAS' Fiscal Agent for data entry/imaging processes. These paper forms be sent to the new Contractor for this contract. As the bulk of PA requests received are FAX or telephonic, the Contractor is expected to process these items in their system prior to transmission to the VAMMIS and these type of transactions are not associated with HIPAA.
115.	Section 4.15 VAMMIS Interface Requirements Page 48	**Please elaborate on the working/collaborative relationship the Department envisions between the Contractor and First Health.** **What contractual obligation does First Health have to work collaboratively with the PA Contractor?**	All Contractors contracted by DMAS are viewed as an extension of DMAS and therefore DMAS views that all Contractors must work together to ensure projects are implemented with minimal problems.

Question Number	Section/ Question	Comment	Response
		In the event technical, operational, administrative and/or related issues arise between First Health and the Contractor, how will these matters be addressed and resolved? i.e. which party establishes interface specifications? In the event disputes arise between First Health and the Contractor how are they to be resolved?	DMAS will be the final arbitrator in all issues/conflicts/problems that may arise during this implementation.
116.	Section 4.15.2 Enrollment Updates Page 48	How will the vendor receive an initial recipient eligibility file? How will this information be updated?	As stated in sections 4.15.2, an initial full file will be available during the implementation phase and will be updated or replaced on various cycles. These processes will be finalized during the implementation phase.
117.	Section 4.15.4 Reference Updates Page 49	What is the frequency of change associated with procedure codes and revenue codes that require Prior Authorization?	HCPCS/CPT procedures and revenue codes are updated annually, and updated on an as needed basis. Statistics are not maintained by DMAS that indicates what percentage of procedures/revenue codes changes is associated with PA requirements.
118.	Section 4.15.4 Reference Updates Page 49	Do providers/enrollees and the contractor receive prior notification of planned changes to the set of procedure codes that require Prior Authorizations?	When changes are implemented that affect procedure codes, DMAS issues Medicaid Memos and other communication to providers and recipients informing them as such, generally 30 days before implementation of the changes. The Contractor is also notified if the changes would affect their workload. Refer to Section 1, Page 12, paragraphs 2 and 3 associated with Contractor notification.
119.	Section 4.15.5 PA Requests Page 49	Does this Section require the Contractor to issue Denial letters or will the fiscal intermediary retain this responsibility?	This section confirms that the generation of letters for notification to both recipient and providers would be retained in the current VaMMIS PA application. The Contractor would not be responsible for this process.
120.	Section 4.15.5 PA Requests Page 49	This Section states; "…The VaMMIS PA application additionally generates letters to providers and recipients as needed for status determination results." What are these letters, how are they different from letters that the Contractor needs to send for Approval or Denials as described in Section 4.6 Review process?	See response to question 119.
121.	Section 4.15.5 PA Requests Page 49	Are there provisions in the fiscal agent prior authorization file transfer process for modifying existing prior authorizations if the patient's condition changes, provider discontinues service, etc.?	There are provisions in the HIPAA 278 transaction for reconsiderations, changes, etc. that would be input to the DMAS' VAMMIS PA Application. The specifics will be addressed by DMAS and the Contractor during the implementation phase
122.	Section 4.15.5 PA Requests Page 49	This Section states that the Contractor will push 278 transactions to the fiscal agent once a day. How does the timing of the once a day batch transmission to the fiscal agent for 278 transactions affect the time requirement to respond to the recipient's request for PA?	PAs, including the 278 transactions, are based on a provider's request, not a recipient's. The process for transmission to the Fiscal Agent and response back from the Fiscal Agent adds 1 day turnaround to the PA adjudication timeline.

Question Number	Section/ Question	Comment	Response
123.	Section 4.15.6 PA Responses Page 49	When will daily fiscal agent prior authorization determinations (results from batch processing) be made available to the contractor? The next business day?	Yes, normally in the AM
124.	Section 4.16 Connectivity to MMIS Fiscal Agent Page 51	The second paragraph indicates that the Department will provide technical assistance to ensure that appropriate equipment and software is obtained for appropriate connectivity. Please provide the details of the equipment/software so that valid proposal cost estimates can be generated.	The Department will be available to assist as necessary to ensure the connectivity between the applicable parties is correct and working. DMAS does not promote any specific software or products, but will be available to help ensure whatever products are used by all parties works as required.
125.	Section 4.16 Connectivity to MMIS Fiscal Agent Page 51	Please specify if any particular software and/or equipment is necessary to establish connectivity with the MMIS vendor. Is the PA vendor expected to cover any interface costs of the MMIS vendor?	The Department will be available to assist as necessary to ensure the connectivity between the applicable parties is correct and working. DMAS does not promote any specific software or products, but will be available to help ensure whatever products are used by all parties' works as required. The PA vendor is not expected to cover any interface costs that would be associated with the MMIS vendor as a result of this RFP. The MMIS vendor already has the capability to use the Secure FTP process for file transfers; therefore no extra cost by the MMIS vendor is envisioned.
126.	Section 4.18 Reporting Requirements Page 54	What would the Department like to see in "Standard reporting packages?" Are these reports produced for other contracts? What software should be used for creating the reports?	The Contractor, as part of the response to this RFP, shall provide reporting packages used in previous Medicaid and public sector contracts.
127.	Section 4.18.8 Satisfaction Surveys Page 55	By "annual," does the Department mean contract year or calendar year? If calendar year, is the contractor expected to conduct a customer satisfaction survey during the first 6 months of the contract (July 1 – December 31, 2006)?	Contract year.
128.	Section 4.18.8 Satisfaction Surveys Page 55	Would the department accept a report within 30 days of completion of the survey rather than 30 days of initiation of the survey? In working with an outside vendor, 30 days from initiation is a very short time frame.	Yes, within 30 days of completion of the survey.
129.	Section 4.18.8 Satisfaction Surveys Page 55	Which providers are surveyed?	The Contractor, as part of the response to this RFP, shall indicate the types of providers to be surveyed.
130.	Section 4.19 Fraud and Abuse Page 56	Please provide more specific details about what policies and procedures are required under 42 CFR Parts 455 and 456 and the relevant Virginia state plan document requirements. Does DMAS have any state specific fraud and abuse related policies, procedures and requirements?	This is standard language that is required in all contracts.
131.	Section 4.19 Fraud and Abuse Page 56	Please provide a copy of any sample or model written fraud and abuse compliance plan documents, policies or procedures that DMAS currently recommends as a basis for a comprehensive	The Department presumes that a Contractor with experience and standard operating procedures shall have in place a fraud and abuse policy and procedure.

Question Number	Section/ Question	Comment	Response
		compliance plan that meets the general requirements specified in the RFP.	
132.	Section 4.19 Fraud and Abuse Page 56	What level of monitoring, investigating and reporting of potential fraud and abuse related activities are required by the contractor under the RFP? What liability does the contractor have if the contractor fails to report a fraud and abuse related matter to DMAS. In the alternative, is the contractor liable for reporting potential fraudulent activities by an enrollee, network provider or subcontractor	See response to question 121.
133.	Section 4.19 Fraud and Abuse Page 56	Please provide more detail of the types of "specific controls" that need to be in place to prevent and detect potential/suspected abuse and fraud for (a) utilization management; (b) relevant subcontractor and provider agreement provisions; (c) written enrollee material regarding fraud and abuse referrals under section 4.19.2.a.iii. of the RFP	See response to question 121.
134.	Section 4.19 Fraud and Abuse Page 56	Please provide more specific details of the role that the contractor will play in cooperating with investigations by DMAS and other State and Federal offices under section 4.19.2.c. of the RFP.	This is dependent upon the type of investigation.
135.	Section 4.19 Fraud and Abuse Page 56	Does the RFP require the vendor to develop and implement a technology based clinical auditing system to help detect, document and monitor potential fraud or abuse related coding errors or knowingly fraudulent upcoding by providers	No.
136.	Section 4.20 Readiness for Implementation Page 57	Can you explain further your requirements for the May 1st deadline? Does all staff have to be hired and trained? If not, who must be hired and trained?	By May 1st, the Contractor shall be able to process all traditional services as listed in this RFP. All Contractor staff shall be hired and trained 30 prior to this date. All Contractor systems should be fully functional at that time.
137.	Section 6.0 Payments to Contractor Page 59	RFP Section 6.0 and Appendix XII do not address details regarding the payment of Startup Costs. In the interest of fairness to vendors for incurred costs during startup, we suggest the Commonwealth allow for startup payments to be structured around the project work plan's major milestones and deliverables with 10 percent of the total startup cost held back for successful Operational readiness review by the Department.	Start up costs may be reimbursed to the contractor 60 days after successful implementation.
138.	Sections 6.2.1 - 6.2.3 Page 59-60	Please specify whether the first fixed monthly payment that will be paid monthly and the payment specified for the "remainder" of the contract period are the same. Will the state please clarify the distinction between the "fixed monthly payment" and the payment for the "remainder of the contract period"?	Delete the sentence "For the remainder of the contract period, the Agency will pay vendor a monthly amount of $ _____."
139.	Section 6.2.1 Fixed Fee Contract Page 59	The RFP states that this is a fixed price contract. After speaking with several companies that publish prior authorization review criteria they indicate that their licensing fees are typically adjusted annually and are calculated based on the number of covered lives in a program. Would DMAS accept a pricing	No. While the Department is aware of licensing fee calculations, the number of lives handled under this contract is anticipated to decrease from year to year. Therefore, the Department will not consider any pass through payments as the Department cannot effectively develop budgets with this methodology.

Question Number	Section/ Question	Comment	Response
		proposal that would "carve out" the review criteria licensing expense and treat that expense as a pass through cost directly to DMAS?	
140.	Section 6.2.2 Payment Modifications Page 60	Could the Department please provide additional information/explanation of what is meant by volume of less than 35% or greater than 65%? We don not understand this formula; please provide an example of how the Department would apply these parameters.	The volume thresholds for renegotiation are PA volume less than 0.35 times the base volume or greater than 1.65 times the base volume.
141.	Section 6.2.4 Payment Modifications Page 60	"In the event of an increase in traditional or Medicaid specific prior authorization volume (via the media specified in this RFP) or a net decrease in traditional or Medicaid specific prior authorization volume (via the media specified in this RFP) of less than 35% or greater than 65%..." Will the state please confirm that this paragraph is intended to mean that the volume thresholds for renegotiation are PA volume less than 0.35 times the base volume or greater than 1.65 times the base volume? Will the state also confirm that it will not seek to renegotiate for changes in volume that do not reach these thresholds?	 Yes, this is correct. Yes, assuming there are no overriding State or Departmental budgetary concerns.
142.	Section 6.2.5 Scope of Work Modifications Page 61	Please explain what is meant by the following sentence, "Any payments for increases or decreases in populations, program, services and/or criteria shall not be considered for future payment adjustments."?	Once a renegotiation has been completed for a population, program, service or criteria, the same changes cannot be applied to future adjustments in volume.
143.	Section 6.2.6 Savings Page 61	The proposal states that, "Cost proposals that offer a guaranteed net savings will receive a proportionately higher score than those who do not offer a guaranteed net savings". Can the State specify the definition of "proportionately higher score" and also provide some historical information in savings achieved in prior contract periods? Can the Department provide historical claims data or medical review data to help calculating what the net savings could be? Is the state seeking additional savings above and beyond those achieved by the current vendor or maintenance of the current	 Savings shall only apply to medical services as listed under the Traditional Services in this RFP. The focus of the program in geared more toward quality than savings. However, the Department would like to know the Contractor's ROI as a benchmark. Payment information may be seen in Exhibit 3 of this addendum. Note: this does not include the InterQual pass through. The Department can not release this data, because it contains Protected Health Information. The Department does not currently calculate savings levels.

Question Number	Section/ Question	Comment	Response
		level of savings? Will the state require a minimum level of guaranteed savings in order to receive the proportionately higher score? Since the minimum level of savings has no bearing on future payments to the PA vendor, yet the evaluation anticipates a proportionately higher score, how will the Commonwealth weight proposals that may present higher or lower savings guarantees that are untested and thus potentially invalid?	 No. However, the Department would like to know the Contractor's ROI as a benchmark. The evaluation team shall evaluate to determine if a Contractor's savings methodology is valid. Department staff, with assistance from consultants, shall make this determination.
144.	Section 6.2.6 Savings Page 61	Will the state please provide data on the total or per member per month dollar value of current traditional and Medicaid services in the targeted population and of the current estimated cost avoidance under the incumbent vendor? Clarified: We are asking for the Current total claims volume for services under PRO management; and the total amount of cost avoidance that can be attributed to the current vendor's management."	Even with clarification, the Department is unsure of what the vendor is asking.
145.	Section 6.2.6 Savings Page 61	Can you give us some idea -- it says just, "receive a proportionately higher score". Can you give us some idea of what that means? Is it one point, or ten percent?	DMAS does not want this to be, quote/unquote, a ROI kind of contract. The ideal is that this contract is focused on utilization and quality. The Department has a responsibility to the Commonwealth to save some money. For traditional services, not so much on the DRG side, but the services that are outpatient, there should be some type of savings. DMAS does not have a number specifically, but will before the bids are actually in. The focus mostly is on the quality side.
146.	Section 6.2.6 Savings Page 61	Will you be giving us some specific methodology? For example, the study looked at just simply care that was -- care plans that were denied. Is that a simple multiplier times your fee schedule? We would assume that some care would be requested that would be denied that, perhaps, for example, would be shifted to a lower level of care or a different modality mix of care and so forth.	No, the Department shall not be providing specific methodology. The Contractor, as part of the response to this RFP, shall propose a savings methodology.
147.	Section 6.2.6 Savings Page 61	So just a caution that this is an area that could conceivably be something that vendors approach very, very differently. And if you're looking at a single number that says, "I am estimating this amount of savings", it may be very, very difficult to have an apples to apples comparison, unless you give us some really specific criteria.	In the past when DMAS has had RFPs like that, we have evaluated each proposal knowing that sometimes it is not apples to apples, oranges to oranges. We are more looking at the proposal to determine if Contractors could substantiate those numbers, could we evaluate those numbers versus being something outrageous like a twenty-two to one return investment that we could not evaluate. The agency tends to be focused on monitoring and evaluation techniques. We are going to look at what Contractors are proposing, and the validity of the proposal.
148.	Section 6.2.6 Savings	Is that guarantee intended to be an insured or secured type of guarantee? Such that you would deduct that amount if someone	No. DMAS does want some kind of benchmark that we are working towards.

Question Number	Section/ Question	Comment	Response
	Page 61	didn't achieve it.	
149.	Section 6.3 Travel Compensation Page 61	States that "the contractor shall not be compensated or reimbursed for travel, meals, or lodging." However, Attachment XII lists travel as a cost component. Can travel for the contract, such as travel for on-site reviews that are required by the contract or travel for meetings with the providers, be included in the contractor's price?	The Contractor will not be paid separately for travel, but can be included as a component of Attachment XII.
150.	Section 7.1 Overview Page 62	It would be helpful for bidders if DMAS would precisely outline where the requirements of Section 7.1 (page 58) and other bidder requirements noted in other parts of the RFP are included in the outline set forth in Section 7.10	The Department is unable to provide this as there are overlapping areas within the RFP and does not want to limit responses.
151.	Section 7.5 Transmittal Letter Page 64	In the Transmittal Letter is it necessary to identify only those contracts and agreements the Offeror has in the state of Virginia? Or, may a potential vendor provide a list in the transmittal letter of all States in which the Offeror currently conducts Medicaid business?	Requirement states that the Offeror must identify any contracts or agreements they have with any state or local government entity. This would include states other than Virginia
152.	Section 7.10.4.1 Staffing Page 67	Could the Department elaborate/clarify what is meant by the term "key staff member"? Would the Department reconsider the information it requires for the references submitted for each "key staff member"? What is meant by the term "previous participants" and what is the consequence should a "key staff member" not possess the requisite experience described in this section?	 No. Previous participant in this regard refers to previous contracts the Contractor may have held. The evaluation team shall consider all experience of the key staff proposed by the Contractor.
153.	Section 7.10.4.1 Staffing Page 67	Given that an Offeror may not currently employ staff in Virginia that would be assigned to this project, nor yet operate a service center location that would be used to service the program; but may have excellent references in completing large scale implementations in numerous states by hiring staff and securing operational facilities post-award; will the Commonwealth accept staff job descriptions and operational proposals in lieu of actual personnel and operations centers in order to assure that capable offerors are evaluated upon a level playing field with incumbent vendors?	Yes, the Department will consider this approach.
154.	Section 9.19 Drug Free Workplace Page 75	Please clarify if it is the State's intention for the drug free workplace notices to specifically label marijuana as a substance of abuse, or if it is sufficient to refer to all controlled substances in accord with the vendor's Drug-Free Workplace policy?	"For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract."

Question Number	Section/ Question	Comment	Response
			It is the Commonwealth's position that marijuana be specified as a substance of abuse.
155.	Section 10.9 Performance Bond Page 80	Please specify the date required by which to have the performance bond in place.	Bonds shall be filed with the purchasing office that awarded the contract or a designated official thereof within 10 days after receipt of the purchase order or notice of award. DMAS would expect receipt of said bond within 10 days after signature of contract.
156.	Section 10.10 Payment Page 80	Please specify or provide an expected payment schedule. What is the anticipated time between the state's receipt of an approved invoice and payment to the vendor?	Payment is made within 30 days of receipt of the vendor's invoice.
157.	Attachment II Page 83	In Appendix XII it appears that the Startup Costs do not get included in the Total carried down on these pricing schedules for evaluation. Please verify this assumption as it appears the Commonwealth did this to level the playing field as the incumbent vendor does not have the burden of startup costs. If this is correct, are Startup Costs included in the evaluated costs for evaluation purposes?	Startup costs will be included in the total cost of the contract and will be included in the evaluated costs for evaluation purposes.
158.	Attachment XII Page 122	If DMAS wants documentation of the number of FTEs included in each pricing component, it would be helpful to have a column included for that information. It also would be helpful to know if start-up costs are being paid separately or should be amortized across the three contract years, with the proportionate share indicated in each year.	Offerors can extrapolate the documentation of the numbers of FTEs by individual or staff category via an attached spreadsheet. However, only the yearly total shall be entered for years 1-3 respectively. See response to question 127
159.	General Questions	Are technical denials (e.g., provider non-compliance) subject to appeal? We recommend that technical denials not be subject to appeal.	All denials are subject to appeal; however, if the issue is truly a technicality, DMAS does have rejection PA Action Reason Codes that can be utilized. A rejection code is used if the provider can correct the technical error or omission and resubmit an entirely new request for the service. Denials, unless overturned in a reconsideration process, must go through the appeals process. The provider has no other recourse for reimbursement.
160.		What percentage of denials is overturned by DMAS?	Acute 48% Psych 55% Intensive Rehab 33% Home Health 0% DME 17% Rehab 0% RTC 5% TFC 11% CBC (including DD) 6% NEOP 54%

Question Number	Section/ Question	Comment	Response
161.		Under the current vendor, WVMI, please describe what services are currently delivered and provide the reimbursement breakdown by service. What is a new service in this RFP compared to the previous contract?	The Department does not have this breakdown by service. The current contract includes prior authorization services and does not include concurrent review, utilization review, desk audits, or site visits.
162.		Please provide a listing of the Medicaid contracted network to include, but not be limited to, hospitals, nursing homes, assisted living facilities, rehab facilities. Also, include the number of admissions by Medicaid provider.	The listing is available on the DMAS web site at www.dmas.virginia.gov The number of admissions is not linked by provider, however information may be available in the Department's statistical response at the following link: http://www.dmas.virginia.gov/ab-2004_stats.htm
163.		Please describe what services prior authorization includes (i.e. Are concurrent reviews required or is it access only?). Is a review required prior to the expiration of the assigned length of stay? If so, which for which services?	The Department is unsure what the Vendor is asking.
164.		What is the six year value of the current contract?	The current yearly value is $5.5 million
165.		What is the value of this current contract year?	$5.5 million
166.		May we get the current annual value of the current contract that's in place, and the prior two years before that?	See response to question 155 and Exhibit 3 attached. Note: this does not include the InterQual pass through.
167.		When does the Department anticipate holding oral presentations?	The evaluation team shall determine the need for oral presentations during the evaluation process.
168.		Has the Department defined the parameters for the oral presentation(s)? If yes, what are they?	Oral presentations may be held telephonically to address specific questions.
169.		When does the Department anticipate awarding this contract?	Refer to Section 7.11 in the RFP.
170.		What organizations submitted responses to the draft RFP?	As the Department was under no obligation to respond to or include suggestions to the draft RFP, the list of organizations submitting responses is irrelevant. Bidders who attended the preproposal conference received a list of potential bidders.
171.		Does the Commonwealth require licensure to perform utilization review activities? If yes, what licensure? Clarified: Some states require that a utilization review organization be licensed by the state before it can perform any reviews. Mississippi is one such state, and a detailed form must be completed and sent along with utilization review policies. Are contractors required to have any such licensure or "approval" from the Commonwealth in order to be eligible to win this contract?	The Contractor should check with all applicable licensing agencies to make this determination.
172.		Will the department provide historical data so that the respondents can supply a response to the potential cost savings to the department?	See response to question 133.
173.		Are there any services in this RFP that are not performed and included under the existing contract, and if so, could you please identify these services?	See response to question 151.

Question Number	Section/ Question	Comment	Response
174.		Please provide utilization data by level of care for psychiatric services, foster care case management services, and intensive in-home services.	Residential Treatment (Level C) - 1,583 Medicaid; 5 FAMIS; 20 Med Expansion TFC Case Management - 1,372 Medicaid; 1 FAMIS Community Based Residential Treatment - (Levels A & B) - 157 Medicaid
175.		With direct data entry and secured email, what are Department's requirements regarding record retention of both paper and electronic records?	Six years for all items, including data, records, paper, files, etc.
176.		Is there a draft contract available for review from the State?	No.
177.		Would the State be willing to allow for a second round of clarifying questions?	No.
178.		It's helpful to us, and I think to the Commonwealth, in terms of getting as responsive a bid as possible, if there's information such as the -- some of the very helpful information you've given us today about things that have been decided in process Is it possible that the Commonwealth would entertain partial postings of answers as you get them, so that bidders would have extra time to consider them in their response, as opposed to waiting until the 21st?	Yes, the first addendum was released on October 12, 2005.

Please complete the following table by checking the appropriate box if services are required under this contract. For example: Inpatient would be both medical/rehab and behavioral health from a management perspective. In addition, DMAS would require prior auth, concurrent review and ongoing case & utilization management. So, all boxes would be checked for inpatient.

Service	Medical / Rehab	Behavioral Health	Prior Auth	Concurrent Review	UM
Inpatient	X	X	X	X	X
Outpatient	X	X	X	X	
Residential Psychiatric Treatment	NA	Yes, only Behavioral Health	Yes	Yes	Desk Review onsite- "concurrent desk review and onsite…"
Foster Care Treatment	NA	Yes, only Behavioral Health	Yes	No	Yes
Intensive In-home services	NA	Yes, only Behavioral Health	No	Yes	Yes
Elderly & Disabled with Consumer Direction Waiver	*	*	X		X
HIV/AIDS Waiver	*	*	X		X
Individual and Family Developmental Disabilities Support Waiver	*	*	X		X
Tech Waiver	*	*	X		X
Alzheimer's Waiver	*	*	X		X
Home and Community Based Waiver					
Adult Companion Care – Agency	*	*	X		X
Adult Companion Care – Consumer Directed	*	*	X		
Adult Day Health Care	*	*	X		X
Assistive Technology	*	*	X		X
Environmental Mods	*	*	X		X
Case Management	*	*	X		X
Crisis Stabilization	*	*	X		X
Day Support Regular	*	*	X		X
Day Support High Intensity	*	*	X		X
Family/Caregiver Training	*	*	X		X
In-Home Residential	*	*	X		X
Nutritional Supplements	*	*	X		X
Personal Care – Agency	*	*	X		X
Personal Care – Consumer Directed	*	*	X		
PERS Monitoring	*	*	X		X
Private Duty Nursing-RN	*	*	X		X
Private Duty Nursing-LPN	*	*	X		X
Respite Care	*	*	X		X

Respite Care - Agency (PC)	*	*	X		X
Consumer Directed	*	*	X		
Skilled Nursing –RN	*	*	X		X
Skilled Nursing - LPN	*	*	X		X
Supported Employment-Individual	*	*	X		X
Supported Employment-Enclave	*	*	X		X
Therapeutic Consultation	*	*	X		X
Prevocational Services	*	*	X		X
PERS RN	*	*	X		X
PERS LPN	*	*	X		X
Crisis Supervision	*	*	X		X
PERS Installation	*	*	X		X
Comprehensive Services Act					
Medicaid		X			X, initial and ongoing review
Non-Medicaid		X			X, initial and ongoing review

***** The service can be reviewed by staff with the type qualifications.

EXHIBIT 1
Reconsiderations and Denials – Question 80

Supervisor Recon Decisions January 1, 2005 - June 30, 2005

Service Type/Unit	Upheld	Overturned	Total Recons
Acute	1923	878	2801
Psych	175	114	289
Intensive Rehab	70	7	77
Home Health	27	22	49
DME	12	68	80
Rehab	23	37	60
RTC	233	474	707
TFC	231	315	546
Outpatient Scans	253	510	763
Waiver Services	48	104	152

Statistics from January 1, 2005 to June 30, 2005 (6 months) for current contract:

Inpatient
Reviews - 62786
Approved - 45980 (73.2%)
Denied - 5784 (9.2%)
Rejected - 6692 (10.6%)
Pended - 4366 (7.0%)

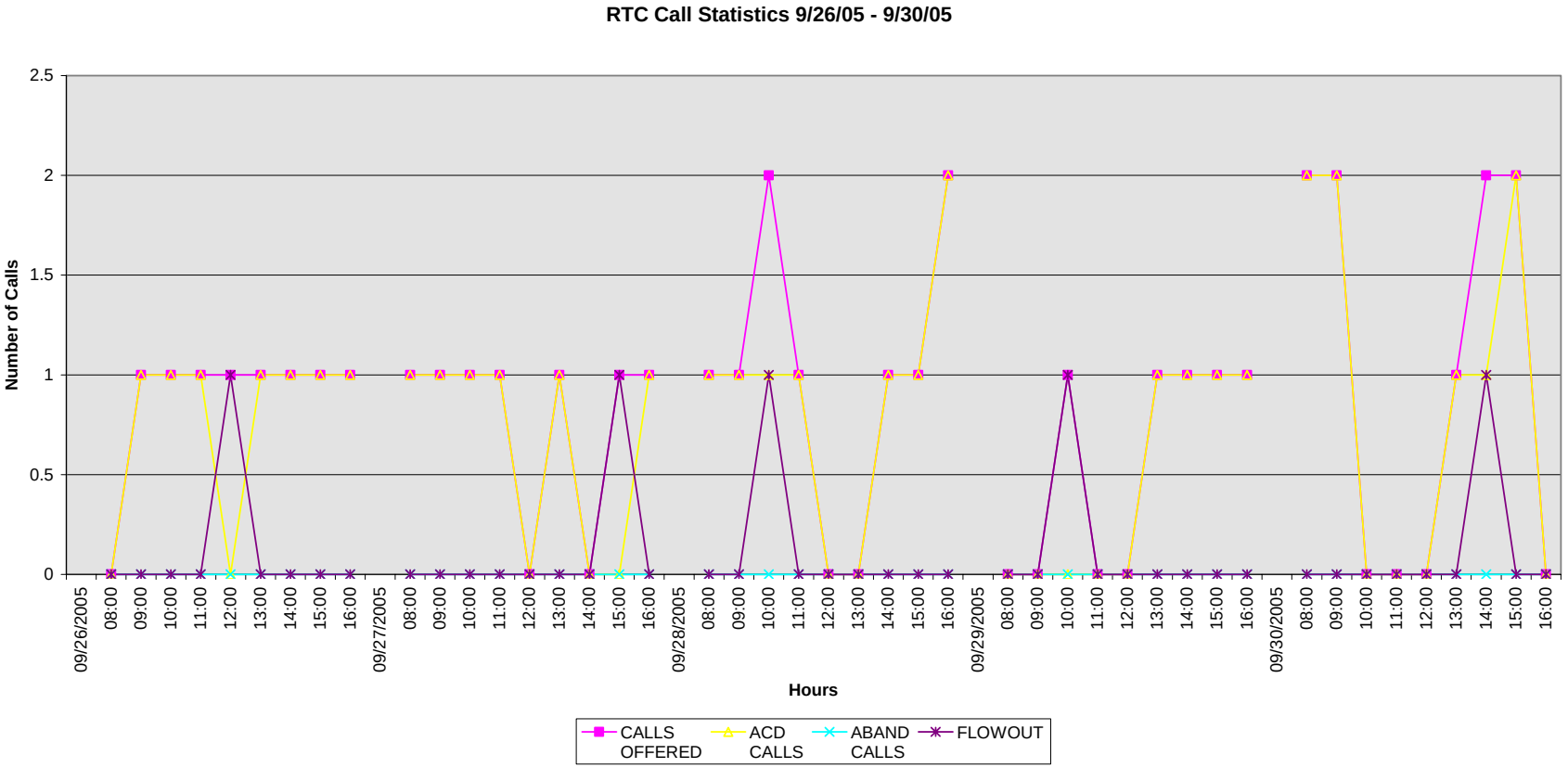
Outpatient
Reviews - 75972
Approved - 62132 (81.8%)
Denied - 2711 (3.6%)
Rejected - 11129 (14.6%)

RTC/TFC
Reviews - 5771
Approved - 3681 (63.8%)
Denied - 1783 (30.9%)
Rejected - 307 (5.3%)

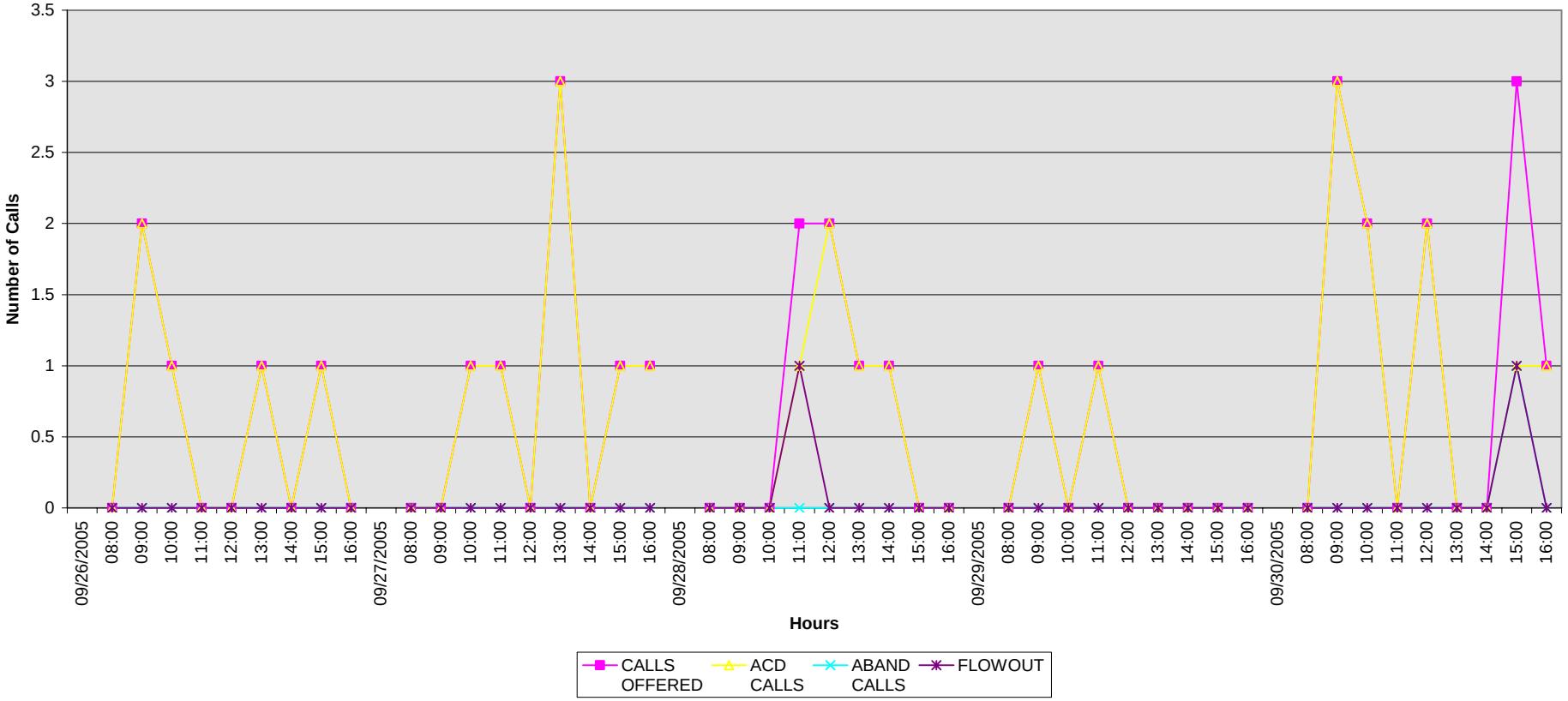
Community Based
Reviews - 15840
Approved - 12076 (76.2%)
Denied - 279 (1.8%)
Rejected - 3485 (22%)

Totals
Reviews - 160369
Approved - 123869 (77.2%)
Denied - 10557 (6.6%)
Rejected - 21613 (13.5%)
Pended - 4366 (2.7%)

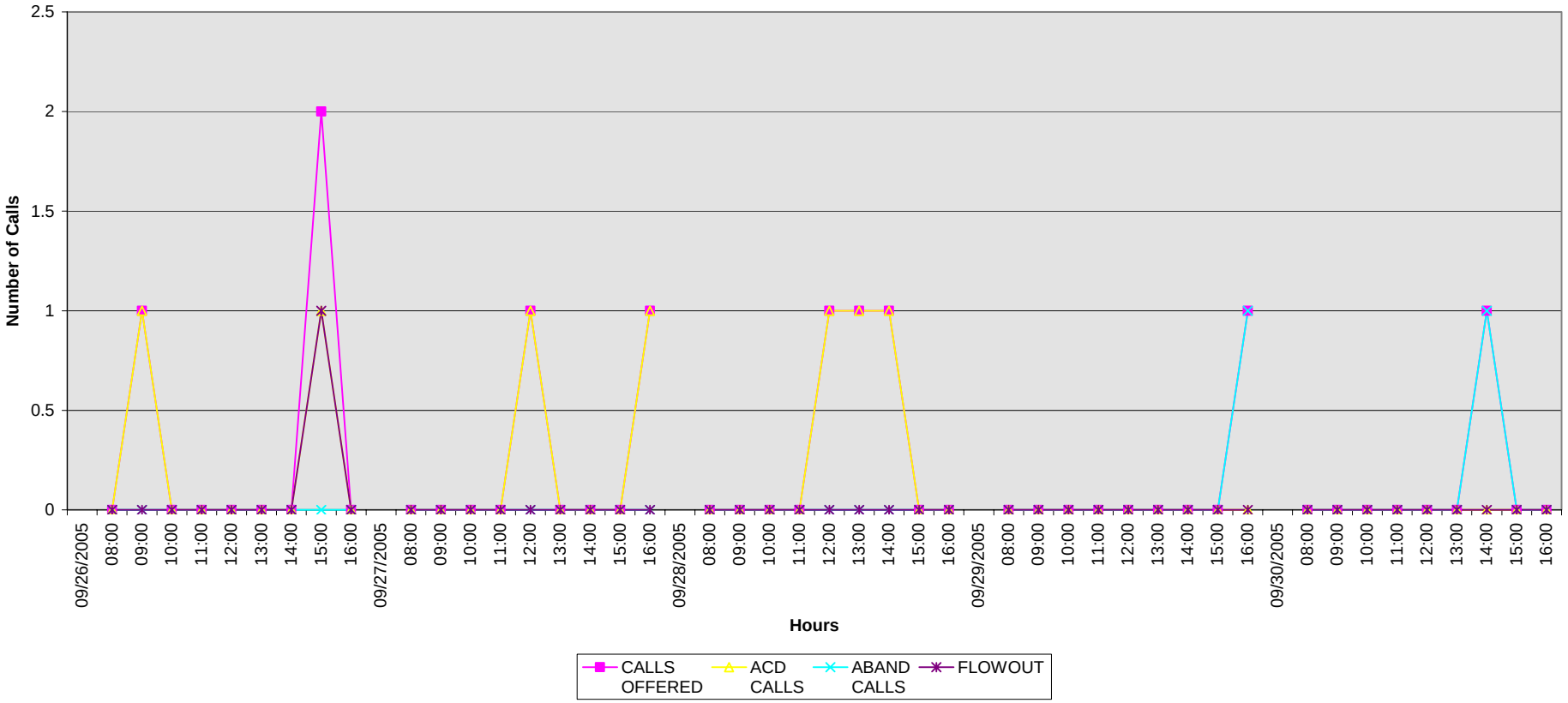
EXHIBIT 2
Call Volumes - Question 100



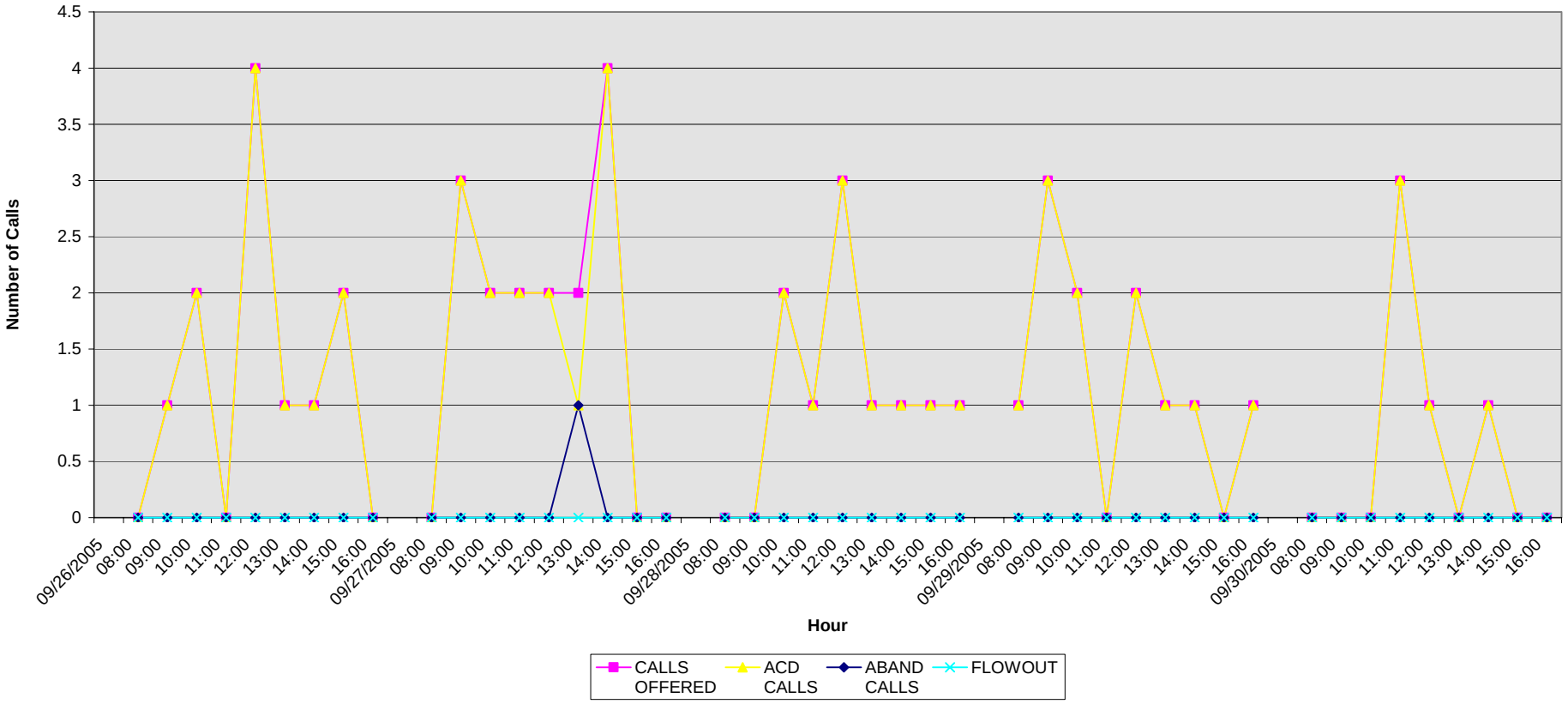
TFC Call Statistics 9/26/05 - 9/30/05



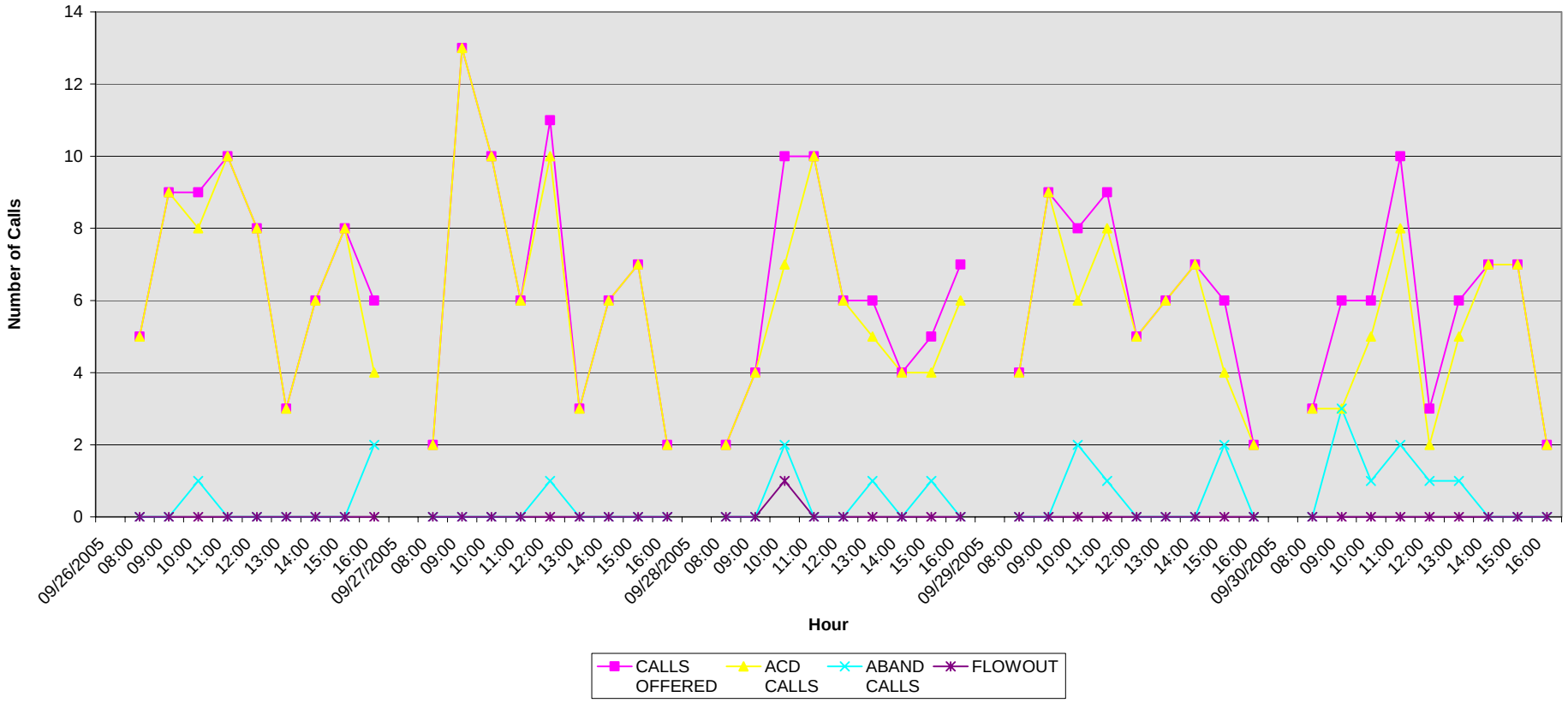
Behavioral Health Inquiry Call Statistics 9/26/05 - 9/30/05



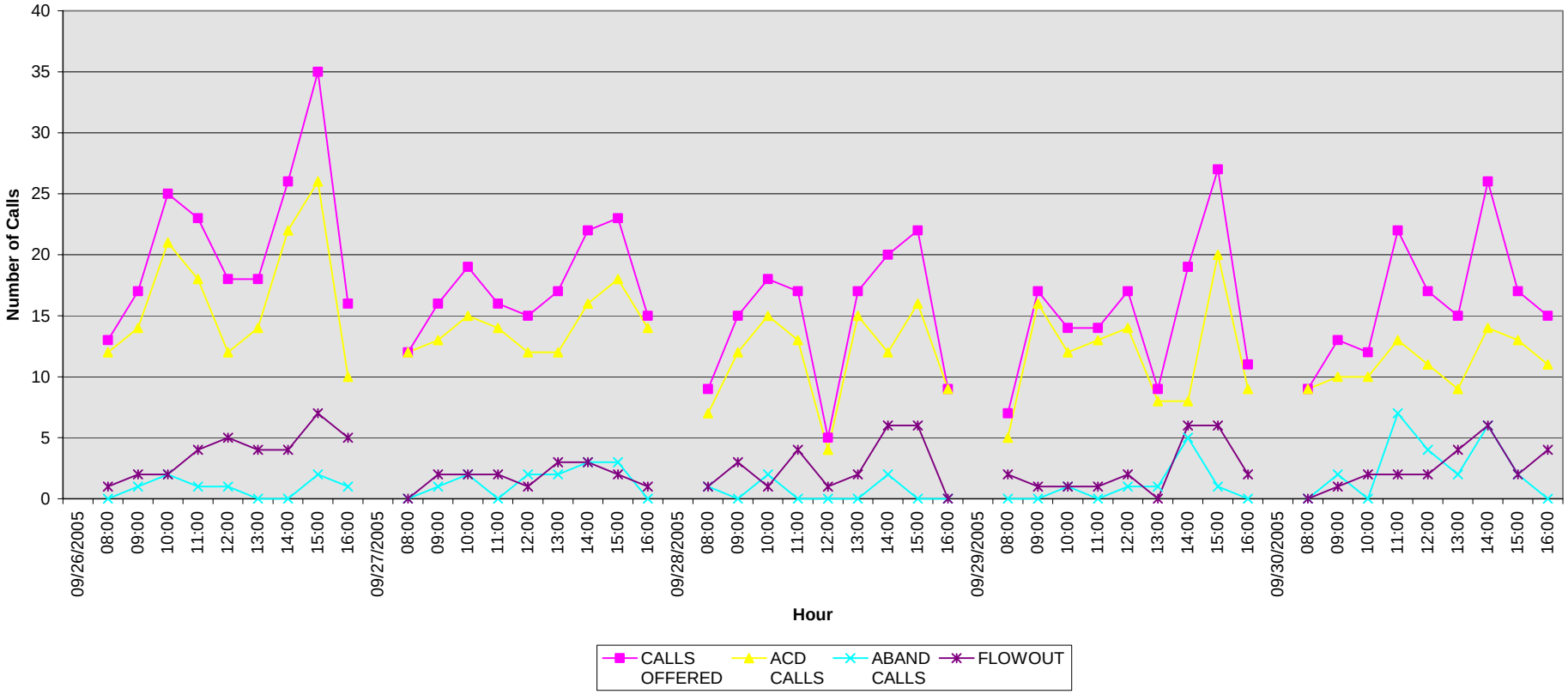
Community Based Care Call Statistics 9/26/05 - 9/30/05



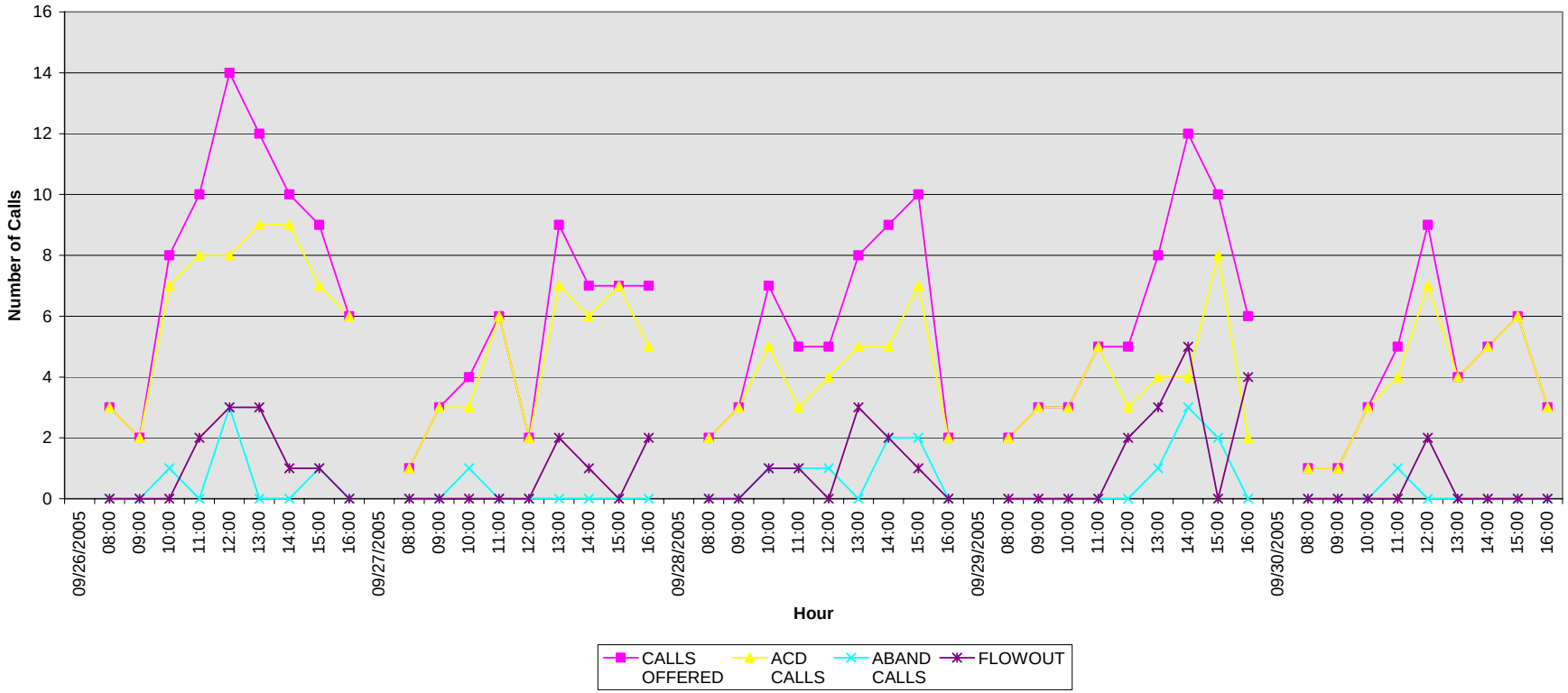
Community Based Care Inquiry Statistics 9/26/05 - 9/30/05



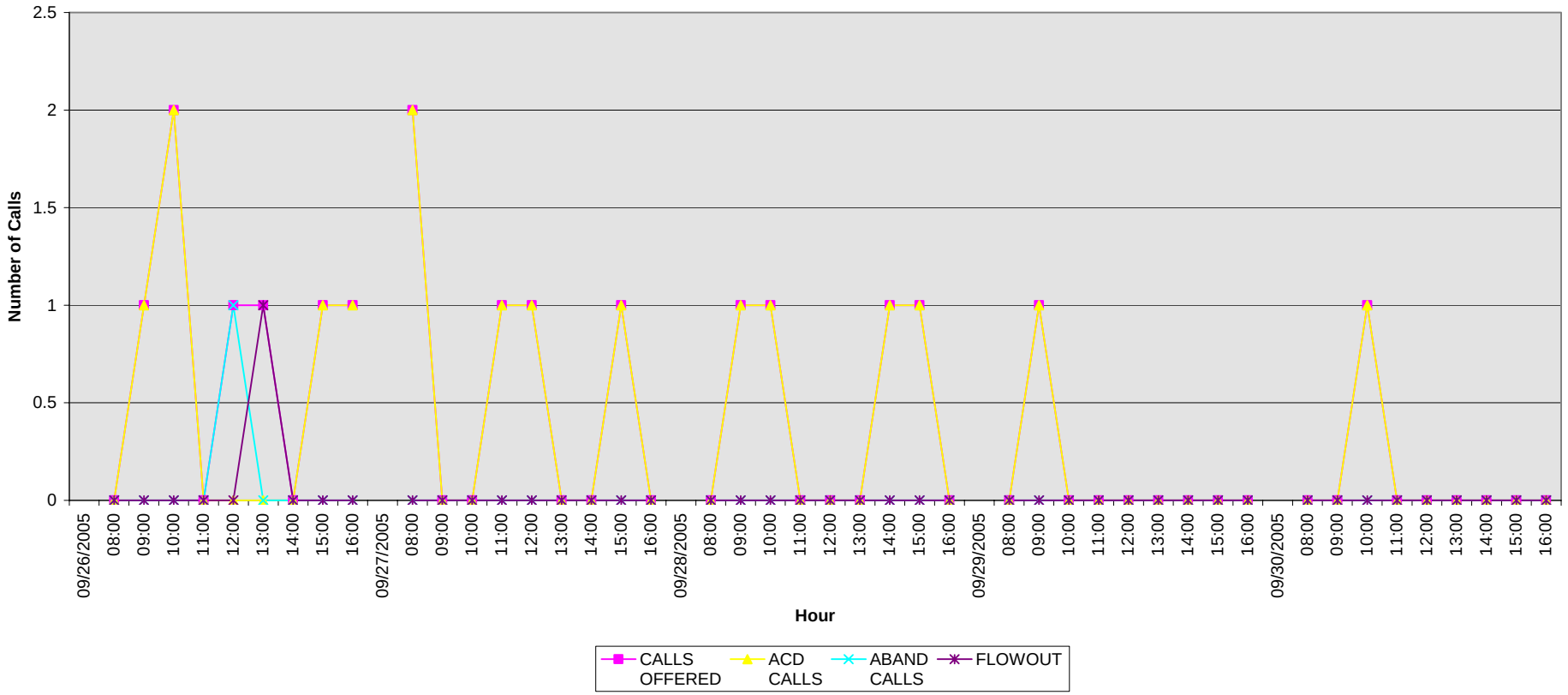
Acute Call Statistics 9/26/05 - 9/30/05



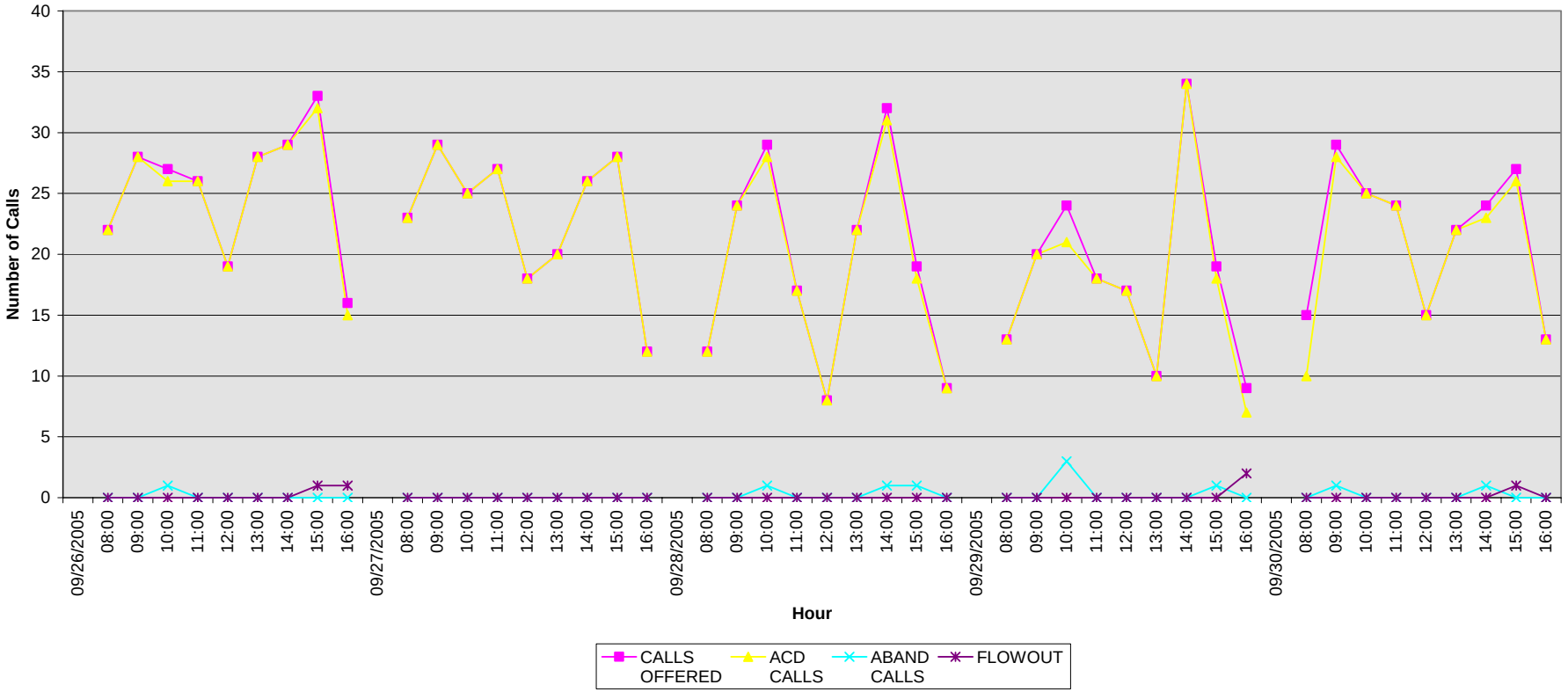
Psych Call Statistics 9/26/05 - 9/30/05



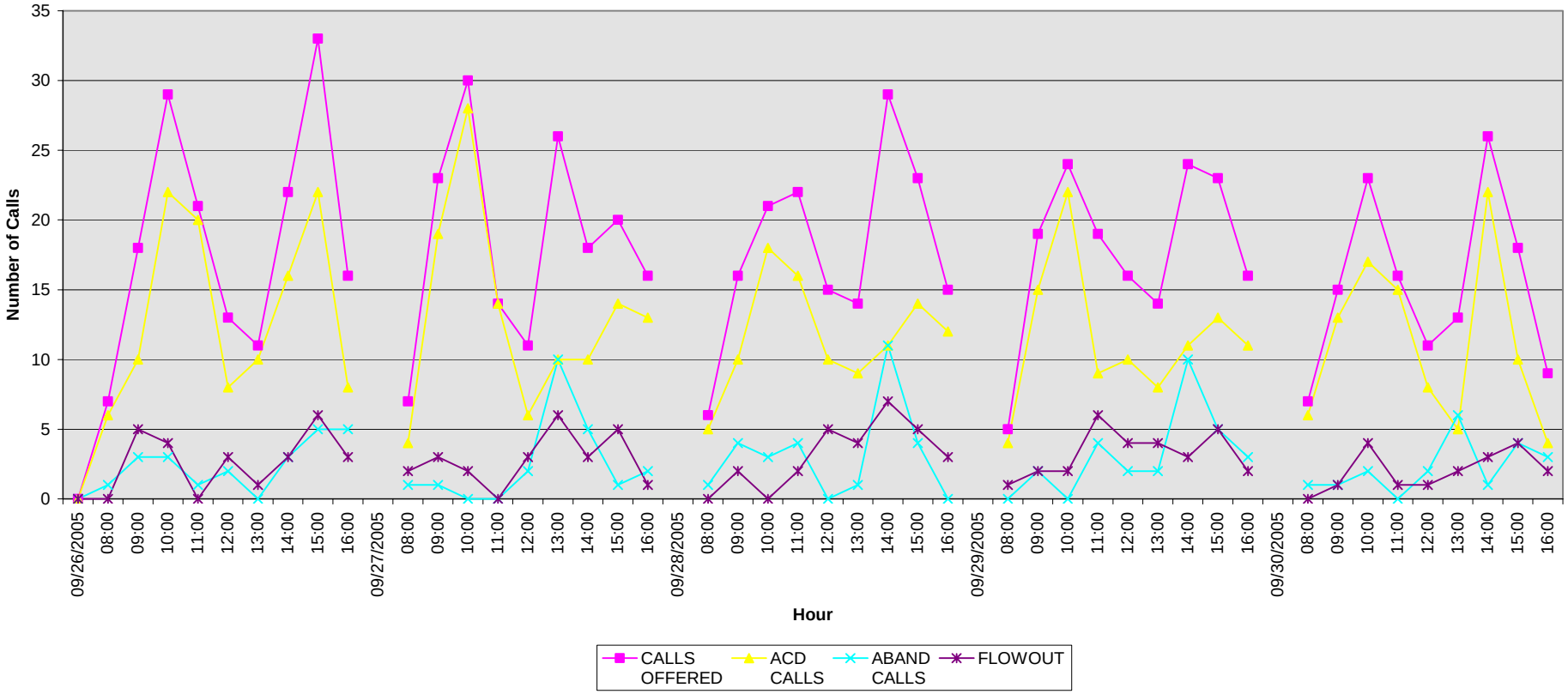
Int Rehab Call Statistics 9/26/05 - 9/30/05



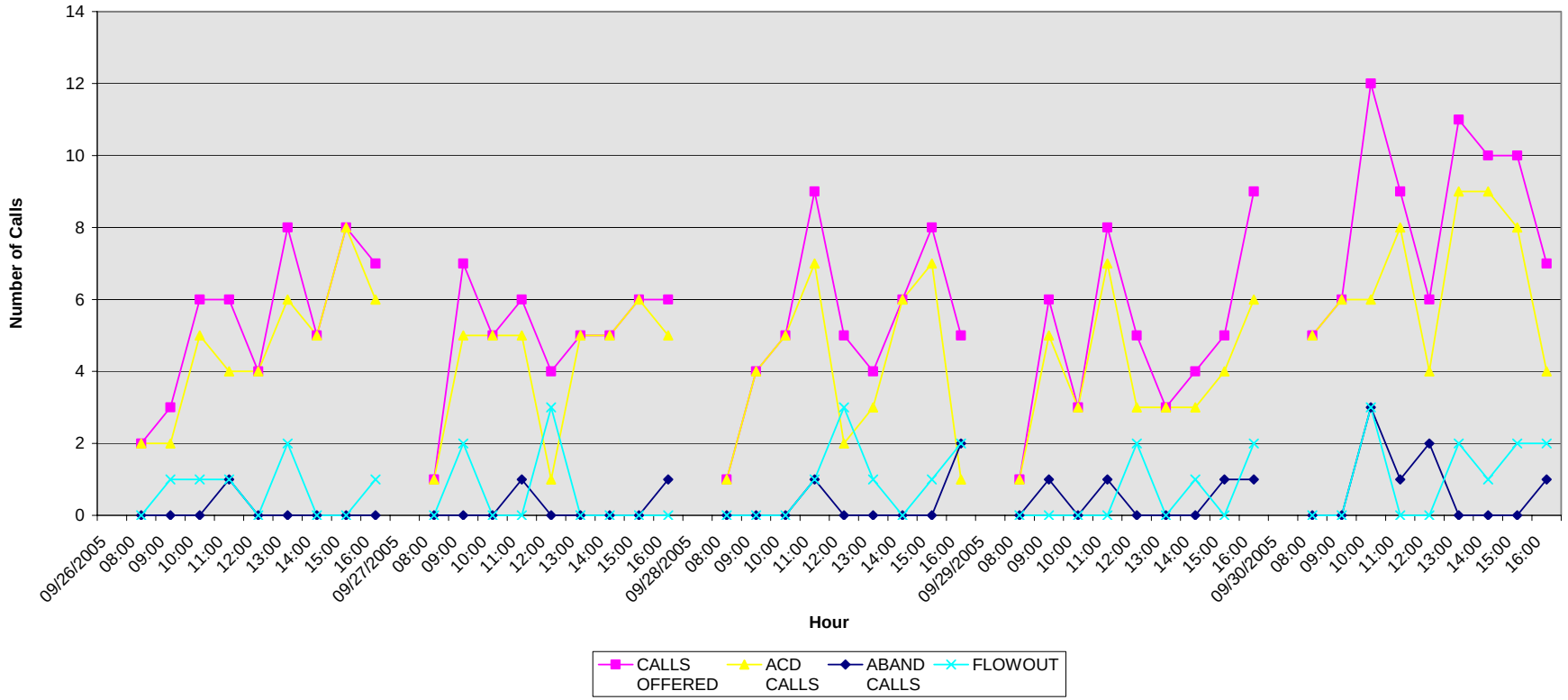
Inpatient Inquiry Call Statistics 9/26/05 - 9/30/05



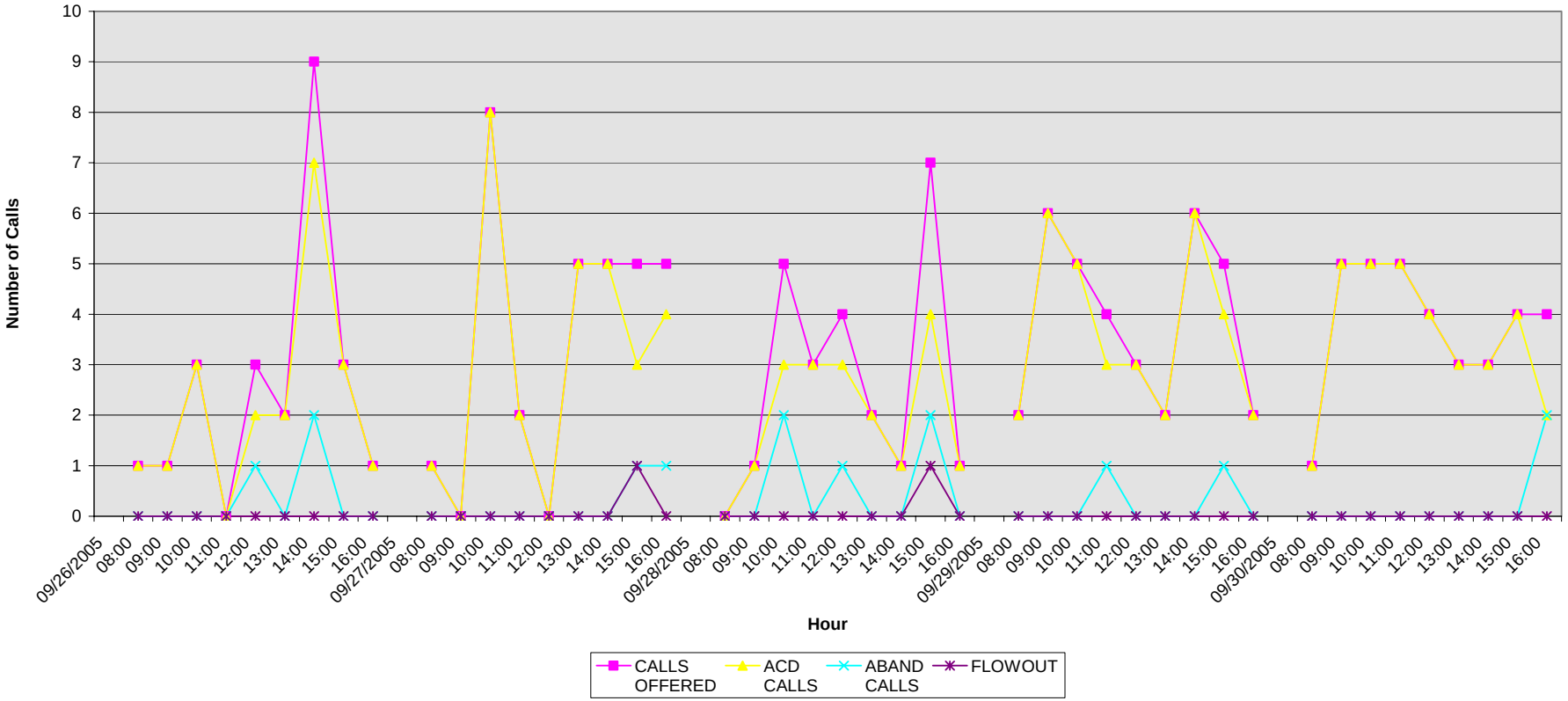
Non-Emergent Outpatient Procedures Call Statistics 9/26/05 - 9/30/05



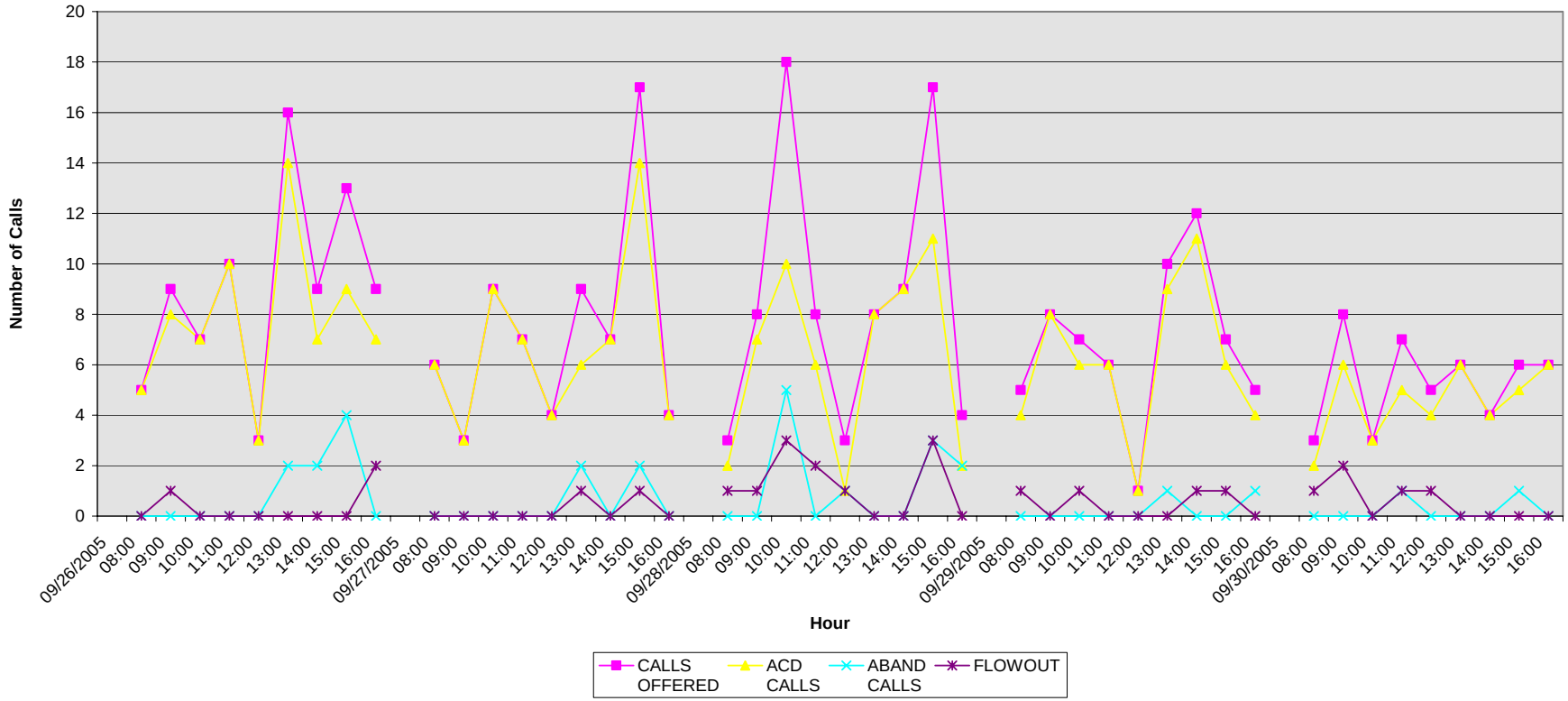
Home Health Call Statistics 9/26/05 - 9/30/05



DME Call Statistics 9/26/05 - 9/30/05



OP Rehab Call Statistics 9/26/05 - 9/30/05



Outpatient Inquiry Call Statistics 9/26/05 - 9/30/05

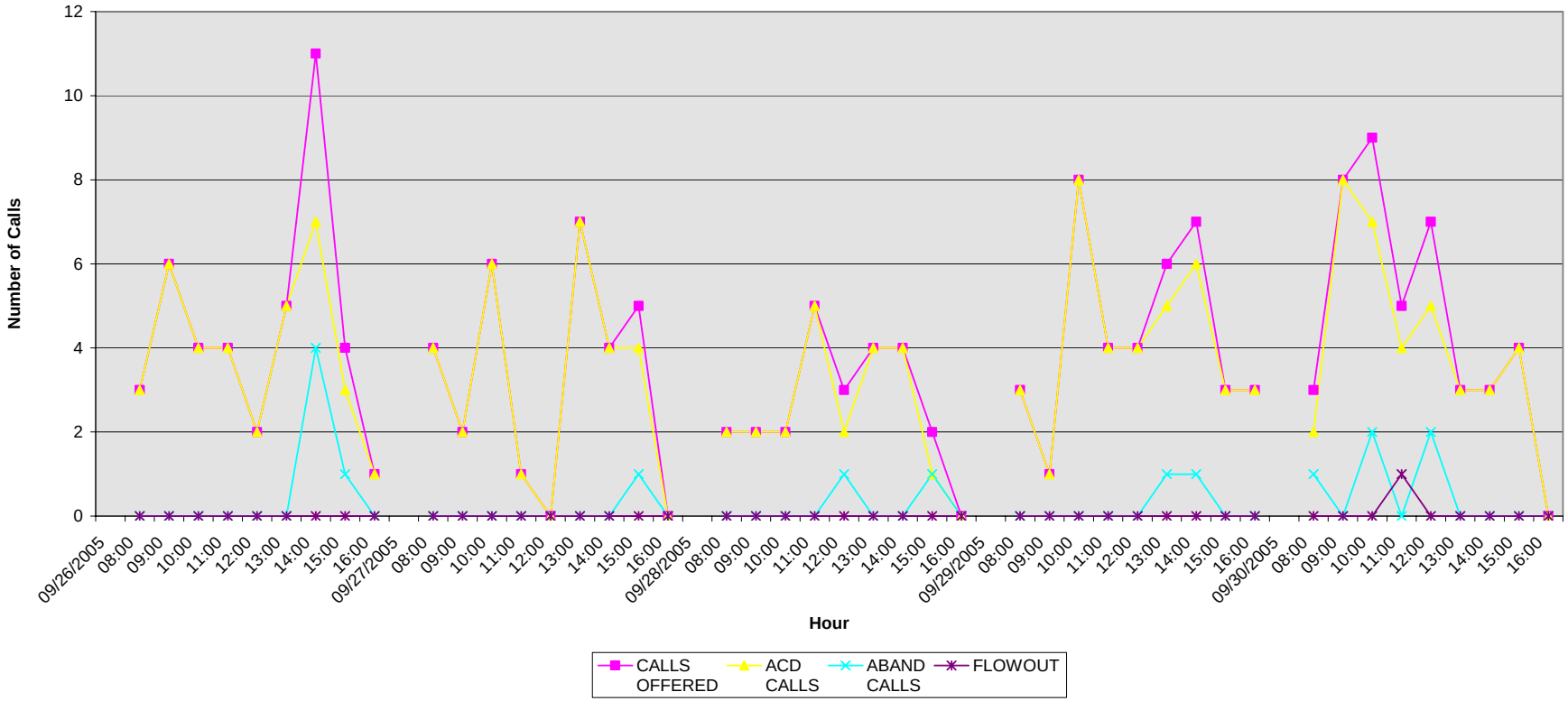


EXHIBIT 3
Payments to Current Contractor – Questions 143 and 166

VENDOR NAME	PAYMENT AMOUNT	VOUCH NO	DATE	FISCAL YR
WEST VIRGINIA MED INST	177,891.70	147432		2002
WEST VIRGINIA MED INST	177,891.71	147432		2002
WEST VIRGINIA MED INST	11,376.66	147432		2002
WEST VIRGINIA MED INST	11,376.67	147432		2002
	378,536.74	**147432 Total**		
WEST VIRGINIA MED INST	177,891.70	147433		2002
WEST VIRGINIA MED INST	177,891.71	147433		2002
WEST VIRGINIA MED INST	11,376.66	147433		2002
WEST VIRGINIA MED INST	11,376.67	147433		2002
	378,536.74	**147433 Total**		
WEST VIRGINIA MED INST	177,891.70	147706		2002
WEST VIRGINIA MED INST	177,891.71	147706		2002
WEST VIRGINIA MED INST	11,376.66	147706		2002
WEST VIRGINIA MED INST	11,376.67	147706		2002
	378,536.74	**147706 Total**		
WEST VIRGINIA MED INST	177,891.70	147721		2002
WEST VIRGINIA MED INST	177,891.71	147721		2002
WEST VIRGINIA MED INST	11,376.66	147721		2002
WEST VIRGINIA MED INST	11,376.67	147721		2002
	378,536.74	**147721 Total**		
WEST VIRGINIA MED INST	177,891.70	148261		2002
WEST VIRGINIA MED INST	177,891.71	148261		2002
WEST VIRGINIA MED INST	11,376.66	148261		2002
WEST VIRGINIA MED INST	11,376.67	148261		2002
	378,536.74	**148261 Total**		
WEST VIRGINIA MED INST	177,891.70	148746		2002
WEST VIRGINIA MED INST	177,891.71	148746		2002
WEST VIRGINIA MED INST	36,837.66	148746		2002
WEST VIRGINIA MED INST	36,837.67	148746		2002
	429,458.74	**148746 Total**		
WEST VIRGINIA MED INST	177,891.70	151417		2002
WEST VIRGINIA MED INST	177,891.71	151417		2002
WEST VIRGINIA MED INST	25,340.41	151417		2002
WEST VIRGINIA MED INST	25,340.42	151417		2002
	406,464.24	**151417 Total**		
WEST VIRGINIA MED INST	177,891.70	151418		2002
WEST VIRGINIA MED INST	177,891.71	151418		2002
WEST VIRGINIA MED INST	25,340.41	151418		2002
WEST VIRGINIA MED INST	25,340.42	151418		2002
	406,464.24	**151418 Total**		
WEST VIRGINIA MED INST	177,891.70	151826		2002
WEST VIRGINIA MED INST	177,891.71	151826		2002

WEST VIRGINIA MED INST	25,340.41	151826		2002
WEST VIRGINIA MED INST	25,340.42	151826		2002
	406,464.24	**151826 Total**		
WEST VIRGINIA MED INST	177,891.70	152389		2002
WEST VIRGINIA MED INST	177,891.71	152389		2002
WEST VIRGINIA MED INST	25,340.41	152389		2002
WEST VIRGINIA MED INST	25,340.42	152389		2002
	406,464.24	**152389 Total**		
WEST VIRGINIA MED INST	177,891.70	155190		2002
WEST VIRGINIA MED INST	177,891.71	155190		2002
WEST VIRGINIA MED INST	25,340.41	155190		2002
WEST VIRGINIA MED INST	25,340.42	155190		2002
	406,464.24	**155190 Total**		
WEST VIRGINIA MED INST	35,811.95	155191		2002
WEST VIRGINIA MED INST	35,811.96	155191		2002
	71,623.91	**155191 Total**		
WEST VIRGINIA MED INST	41,137.72	155490		2002
WEST VIRGINIA MED INST	41,137.73	155490		2002
	82,275.45	**155490 Total**		
WEST VIRGINIA MED INST	35,811.95	155493		2002
WEST VIRGINIA MED INST	35,811.96	155493		2002
	71,623.91	**155493 Total**		
WEST VIRGINIA MED INST	186,119.25	155909		2002
WEST VIRGINIA MED INST	186,119.25	155909		2002
WEST VIRGINIA MED INST	25,340.41	155909		2002
WEST VIRGINIA MED INST	25,340.42	155909		2002
	422,919.33	**155909 Total**		
WEST VIRGINIA MED INST	186,119.25	156053		2002
WEST VIRGINIA MED INST	186,119.25	156053		2002
WEST VIRGINIA MED INST	25,340.41	156053		2002
WEST VIRGINIA MED INST	25,340.42	156053		2002
	422,919.33	**156053 Total**		
	5,425,825.57	**Grand Total**		

VENDOR NAME	PAYMENT AMOUNT	VOUCH NO	DATE	FISCAL YR
WEST VIRGINIA MED INST	170,190.75	157310	20020916	2003
WEST VIRGINIA MED INST	170,190.75	157310	20020916	2003
WEST VIRGINIA MED INST	25,340.41	157310	20020916	2003
WEST VIRGINIA MED INST	25,340.42	157310	20020916	2003
	391,062.33	**157310 Total**		
WEST VIRGINIA MED INST	170,190.75	160275	20021118	2003
WEST VIRGINIA MED INST	170,190.75	160275	20021118	2003
WEST VIRGINIA MED INST	25,340.41	160275	20021118	2003
WEST VIRGINIA MED INST	25,340.42	160275	20021118	2003
	391,062.33	**160275 Total**		

WEST VIRGINIA MED INST	170,190.75	160654	20021210	2003
WEST VIRGINIA MED INST	170,190.75	160654	20021210	2003
WEST VIRGINIA MED INST	25,340.41	160654	20021210	2003
WEST VIRGINIA MED INST	25,340.42	160654	20021210	2003
	391,062.33	**160654 Total**		
WEST VIRGINIA MED INST	170,190.75	161037	20030109	2003
WEST VIRGINIA MED INST	170,190.75	161037	20030109	2003
WEST VIRGINIA MED INST	25,340.41	161037	20030109	2003
WEST VIRGINIA MED INST	25,340.42	161037	20030109	2003
	391,062.33	**161037 Total**		
WEST VIRGINIA MED INST	170,190.75	161038	20030109	2003
WEST VIRGINIA MED INST	170,190.75	161038	20030109	2003
WEST VIRGINIA MED INST	25,340.41	161038	20030109	2003
WEST VIRGINIA MED INST	25,340.42	161038	20030109	2003
	391,062.33	**161038 Total**		
WEST VIRGINIA MED INST	159,815.75	161838	20030310	2003
WEST VIRGINIA MED INST	159,815.75	161838	20030310	2003
WEST VIRGINIA MED INST	8,446.83	161838	20030310	2003
WEST VIRGINIA MED INST	8,446.84	161838	20030310	2003
	336,525.17	**161838 Total**		
WEST VIRGINIA MED INST	196,575.75	161925	20030321	2003
WEST VIRGINIA MED INST	196,575.75	161925	20030321	2003
WEST VIRGINIA MED INST	16,893.62	161925	20030321	2003
WEST VIRGINIA MED INST	16,893.63	161925	20030321	2003
	426,938.75	**161925 Total**		
WEST VIRGINIA MED INST	112,930.21	167659	20030428	2003
WEST VIRGINIA MED INST	112,930.22	167659	20030428	2003
	225,860.43	**167659 Total**		
WEST VIRGINIA MED INST	144,813.08	168245	20030605	2003
WEST VIRGINIA MED INST	144,813.09	168245	20030605	2003
WEST VIRGINIA MED INST	18,545.25	168245	20030605	2003
WEST VIRGINIA MED INST	18,545.25	168245	20030605	2003
	326,716.67	**168245 Total**		
WEST VIRGINIA MED INST	144,813.08	168249	20030605	2003
WEST VIRGINIA MED INST	144,813.09	168249	20030605	2003
WEST VIRGINIA MED INST	18,545.25	168249	20030605	2003
WEST VIRGINIA MED INST	18,545.25	168249	20030605	2003
	326,716.67	**168249 Total**		
WEST VIRGINIA MED INST	144,813.08	168596	20030625	2003
WEST VIRGINIA MED INST	144,813.09	168596	20030625	2003
WEST VIRGINIA MED INST	18,545.25	168596	20030625	2003
WEST VIRGINIA MED INST	18,545.25	168596	20030625	2003
	326,716.67	**168596 Total**		
WEST VIRGINIA MED INST	186,119.25	0156628N	20020801	2003
WEST VIRGINIA MED INST	186,119.25	0156628N	20020801	2003
WEST VIRGINIA MED INST	25,340.41	0156628N	20020801	2003

WEST VIRGINIA MED INST	25,340.42	0156628N	20020801	2003
	422,919.33	**0156628N Total**		
	4,347,705.34	**Grand Total**		

VENDOR NAME	PAYMENT AMOUNT	VOUCH NO	DATE	FISCAL YR
WEST VIRGINIA MED INST	391,903.67	0169170N	20030829	2004
WEST VIRGINIA MED INST	365,872.98	169253	20030911	2004
WEST VIRGINIA MED INST	364,838.67	169467	20031014	2004
WEST VIRGINIA MED INST	364,838.67	169716	20031120	2004
WEST VIRGINIA MED INST	364,838.67	169857	20031217	2004
WEST VIRGINIA MED INST	364,838.67	170092	20040122	2004
WEST VIRGINIA MED INST	507,296.04	170150	20040202	2004
WEST VIRGINIA MED INST	364,838.67	170568	20040315	2004
WEST VIRGINIA MED INST	364,838.67	170775	20040415	2004
WEST VIRGINIA MED INST	364,838.67	170973	20040511	2004
WEST VIRGINIA MED INST	401,536.00	171399	20040618	2004
WEST VIRGINIA MED INST	183,488.75	171400	20040618	2004
	$ 4,403,968.13			
WEST VIRGINIA MED INST	401,536.00	0171712P	20040728	2005
WEST VIRGINIA MED INST	401,536.00	0171853N	20040818	2005
WEST VIRGINIA MED INST	401,536.00	172071	20040921	2005
WEST VIRGINIA MED INST	401,536.00	172247	20041019	2005
WEST VIRGINIA MED INST	401,536.00	172526	20041117	2005
WEST VIRGINIA MED INST	401,536.00	172778	20041228	2005
WEST VIRGINIA MED INST	48,925.00	172779	20041228	2005
WEST VIRGINIA MED INST	401,536.00	172872	20050120	2005
WEST VIRGINIA MED INST	410,634.00	173101	20050224	2005
WEST VIRGINIA MED INST	410,634.00	173288	20050317	2005
WEST VIRGINIA MED INST	86,892.44	173364	20050329	2005
WEST VIRGINIA MED INST	420,787.68	173581	20050422	2005
WEST VIRGINIA MED INST	420,787.68	173758	20050523	2005
WEST VIRGINIA MED INST	514,033.93	173871	20050610	2005
WEST VIRGINIA MED INST	420,787.68	173872	20050610	2005
	$ 5,544,234.41			
WEST VIRGINIA MED INST	420,787.68	0174515N	20050815	2006
WEST VIRGINIA MED INST	420,787.68	174798	20050919	2006
	$ 841,575.36			

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
http://www.state.va.us/~dmas/dmas.html

MEDICAID MEMO

MEMO	Special
DATE	9-22-97

TO: All Hospitals and Physicians Participating in the Virginia Medical Assistance Program and Health Maintenance Organizations Providing Services to Virginia Medicaid Recipients

FROM: Joseph M. Teefey, Director
Department of Medical Assistance Services

SUBJECT: Preauthorization Changes Affecting Maternity/Newborn Inpatient Hospitalizations and Preauthorization Reminders

The purpose of this memo is to inform you that the Department of Medical Assistance Services (DMAS) will no longer require preauthorization for normal maternity/newborn inpatient care effective for all claims received on or after October 6, 1997. This memo also provides some preauthorization reminders.

MATERNITY AND NEWBORN INPATIENT CARE

Normal vaginal deliveries, ICD-9 CM diagnosis code range 650 through 659, with a length of stay less than or equal to three days from the date of admission, will no longer require preauthorization. Cesarean section deliveries, ICD-9 CM procedure code range 74.1 through 74.99, with a length of stay less than or equal to five days from the date of admission, will also no longer require preauthorization. It is important to remember that these lengths of stay are calculated from the date of admission and not the date of delivery. The DMAS contractor, West Virginia Medical Institute (WVMI), must preauthorize maternity stays which do not fall within these parameters. This preauthorization must be on file with DMAS prior to billing for the stay.

Newborns who are in the normal nursery, Revenue Code 170 or 171, with a length of stay less than or equal to five days from the infant's date of birth, will no longer require preauthorization. Preauthorization will be required for the entire newborn stay if the infant is in any other nursery setting (i.e., Revenue Codes 172, 179 or 175) for any part of the stay. It is important to remember that for newborns, the infant may only be in the normal nursery (Revenue Code 170 or 171), and the length of stay is calculated from the date of birth and may not exceed five days. WVMI must preauthorize newborn stays which do not fall within these parameters. This preauthorization must be on file with DMAS prior to billing for the stay.

The changes outlined above have no impact on the mandated maternal lengths of stay as defined in the Medicaid Memo dated 6/26/96.

If preauthorization will be required, telephone WVMI at 648-3159 (local Richmond) or 1-800-299-9864 (all other areas toll free). Effective immediately, WVMI will no longer process facsimile requests on the "Labor and Delivery Fax Request Log." However, WVMI will accept facsimile requests for planned/scheduled admissions for surgery and Temporary Detention Orders (TDO). Use the "Virginia Medicaid Utilization Management" form (copy attached) to fax these preauthorization requests. The following fax numbers are available for your use:

648-6880	Richmond Area
1-888-243-2770	All other areas (toll free)

(over)

PREAUTHORIZATION REMINDERS

To minimize your time on the phone, we suggest the following when calling for preauthorization:

- Peak hours for telephonic review are between 2:00 and 5:00 P.M. You may wish to place your preauthorization call earlier in the day.

- Have available all the necessary demographic and clinical information you will need in order to obtain the preauthorization. Inadequate clinical information may result in your request being pended for additional information. This requires you to call WVMI back with the additional clinical information needed. By being prepared, you can avoid this call back.

- Procedures done as an outpatient do not require preauthorization. However, if the patient is subsequently admitted to the hospital due to post operative complications, you must call to have the admission and length of stay preauthorized.

- Medicaid defines "observation" as outpatient services and does not require preauthorization.

- No telephone call is necessary if the patient is discharged prior to the date the length of stay assignment ends. However, you must call WVMI to extend the length of stay if the patient stays beyond the assigned length of stay. The exception to this is for the adult patient who stays beyond 21 days. The hospital is only responsible for obtaining preauthorization for the first 21 days of inpatient care. For patients under the age of 21, all inpatient days must be preauthorized. The only exception is a newborn in the normal nursery for five days or less from the date of birth, as previously discussed.

- Requests for cosmetic surgery or transplant surgery, with the exception of corneal transplants, must first be sent in writing to the Director of Medical Support of the Department of Medical Assistance Services. Once the procedure has been authorized, contact WVMI to obtain authorization if inpatient admission is required. Cosmetic surgery performed solely to enhance appearance is not a covered service.

HEALTH MAINTENANCE ORGANIZATIONS

This Medicaid Memo does not apply to HMOs and is provided for information only.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

786-6273	Richmond Area
1-800-552-8627	All Other Areas

Please remember that the "HELPLINE" is for provider use only.

Attachment

CONFIDENTIAL

VA MEDICAID UTILIZATION MANAGEMENT

WVMI Use

WVMI Authorization _____

L.O.S. _____

☐ Initial Review ☐ Concurrent Review

A. Patient Medicaid ID: _____

B. Hospital Name: _____ Provider #: _____

Hospital Phone: _____ Extension: _____

Hospital Fax: _____ Contact Name: _____

C. Admitting Physician: _____ Phone: _____

D. Patient Name: _____

Last First MI

Date of Birth: _____ Sex: ☐ M ☐ F

E. Admission Type: ☐ Elective ☐ Urgent ☐ Emergency

Still a Patient? ☐ Yes ☐ No

F. Admission Date: _____ /Discharge Date: _____

G. Setting: ☐ Inpatient ☐ Inpatient Psych

H. ICD-9 Code(s): _____

Description: _____

I. Severity of Illness (Initial Only): _____

J. Abnormal Lab/ Imaging Findings: _____

K. Intensity of Service/ Treatment Plan: _____

Authorization does not guarantee reimbursement.

Voice:

800-299-9864 Toll-Free

•Continued stay for hospital inpatient, press 1

•Continued stay for psychiatric inpatient, press 2.

804-648-3159 Richmond Area

Fax

888-243-2770 Toll-Free

804-648-6880 Richmond Area

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

JOSEPH M. TEEFEY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4512 (Fax)
800/343-0634 (TDD)

December 29, 1997

MEMORANDUM

TO: Hospitals Participating in the Virginia Medical Assistance Program

FROM: James P. Cohen, Manager, Program Services
Division of Program Operations

SUBJECT: Changes affecting preauthorization and billing for normal vaginal deliveries and alcohol and drug rehabilitation and detoxification

Effective immediately, all claims received for vaginal deliveries, with an ICD-9 CM procedure code within the following ranges 72.0-72.9, 73.0-73.09, 73.2-73.22, 73.5-73.99, 75.50-75.69 and 75.8, will no longer require preauthorization if the length of stay is not greater than three (3) days. Refer to your Medicaid Memo dated 9/22/97 for Cesarean Section and normal newborn processing.

In addition, effective immediately, claims with an alcohol/drug rehabilitation and detoxification ICD-9 CM procedure code, 94.6-94.69, will no longer deny for "services not covered" if there is a preauthorization on file. Alcohol and drug rehabilitation and detoxification remain non-covered services under the Virginia Medicaid program. However, the Department of Medical Assistance Services (DMAS) recognizes that medical detoxification is, at times, part of a medically appropriate treatment plan. DMAS will conduct retrospective audits of these authorizations to ensure that the criteria for medical necessity is met.

Please address questions regarding these changes to the DMAS Provider Helpline at the following numbers:

Toll Free: 1-800-552-8627
Local: 786-6273

JPC:cbt

26\j:\cohen\medmems\changes